

# MANAGEMENT TRAINING FOR PRIMARY HEALTH CARE

**ASSESSMENT OF  
MANAGEMENT TRAINING NEEDS**



आरोग्यम् मृतमम्पदा

**राष्ट्रीय स्वास्थ्य एवं परिवार कल्याण संस्थान**

**NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE,**

**NEW DELHI**



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ONLY FOR  
REFERENCE

**MANAGEMENT TRAINING  
FOR  
PRIMARY HEALTH CARE**

**—A COLLABORATIVE STUDY**

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# **MANAGEMENT TRAINING FOR PRIMARY HEALTH CARE**

**ASSESSMENT OF MANAGEMENT TRAINING  
NEEDS FOR STAFF AT PRIMARY HEALTH  
CENTRE AND BELOW**



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**NEW DELHI**

MANAGEMENT TRAINING  
FOR  
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TM-120  
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Published by National Institute of Health and Family Welfare, New Mehrauli Road, New Delhi-110067 and printed at Allied Publishers Pvt. Ltd. New Delhi-110064

First Edition: 1986/3000



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## Preface

During the British Rule in India administration in government offices had been standardised by rules, regulations and code of conduct framed for this purpose from time to time. The civil servants were given training in rules and procedures of administration before appointment and were put on probation for some period. All the revenue officers were given training on the job. The same system is being followed now for Indian Administrative Service officers.

However, in various technical and scientific spheres and activities of development the stress has been laid on development of technical skills.

In the post-war period, importance was laid on organisation and management of industries and business to increase productivity and to develop good personnel morale. The institutes of management have been set-up and courses in business administration have been started in the universities to prepare young graduates to fill up managerial and executive positions.

While the importance of management in the health field has been realised, not much skill has yet been noticed in the organisation of available resources of manpower and material for delivery of health care nor any systematic training has been imparted to the technical personnel (either the doctors, para-professionals or para-medicals) towards this end. Consequently, the community has not yet got the full benefit of the available health facilities. Besides, many of the health programmes are not fully accepted and utilised by the community due to lack of awareness and understanding of the benefits arising therefrom. The health functionaries have not been adequately equipped to communicate, inform and get the people to participate in programmes meant for them.

The World Health Organization has been urging upon the member countries for the past two decades to pay sufficient attention to this great need of management training to health personnel. This has been emphasised in the joint report of the WHO and UNICEF at Alma Ata in 1978.

To enable the member countries to develop suitable strategies to strengthen management aspects of the health system, the WHO has brought out series of documents in public health management. The paper on modern management methods in the organisation of health services is also a useful document for this purpose.



In the Indian context some attempts have recently been made to improve the management training to medical officers of primary health centre and district and state level officers. The National Institute of Health Administration and Education, now merged into the National Institute of Health and Family Welfare (NIHFW) had made a beginning in this direction, involving the Institutions of Management at Ahmedabad, Bangalore and the Administrative Staff College, Hyderabad. But these institutions could give only a small coverage as against the large number of medical officers to be trained in the country. Also, no systematic management training had been undertaken in any institution for the block level staff other than the medical officers. Moreover, no worthwhile attempt has yet been made to identify the training needs for different categories of health functionaries and to develop proper curriculum. It is in this context the decision of the NIHFW to undertake a study on health management training, with initial seed money assistance from the World Health Organisation, Geneva, may be said to have made a new beginning.

In order to give it wider geographical coverage and utilise the management training experience of other institutions, this study was undertaken by NIHFW in collaboration with Institutes of Management at Ahmedabad and Bangalore and the Gandhigram Institute of Rural Health and Family Welfare Trust. Each Institute took one State in one region of the country to study the problem. The NIHFW coordinated this study.

The management training needs for different categories of workers at the primary health centre (PHC) level and below were identified through four approaches:

- Analysis of the job functions to identify the components of management.
- Interview technique for data collection on the pattern of functioning of the workers, including their planning activities.
- Participatory observation on functioning of workers, to determine pattern of their role functioning; and
- Organisation of a workshop for the primary health centre, district and state level officers to determine the management problems and the training needs of the workers at PHC level.

The collaborating institutes were called upon to develop training modules in terms of the needs for different categories of health workers of the primary health centre, including the medical officers and try out their feasibility and effectiveness. The experiences thus gained would be fed back into making the final modules of training.

The identification of training needs for different workers at the PHC level and below, using the four approaches as stated above, constitutes this report. The management training modules, as developed on basis of training needs and the experiences gained from the feasibility study to overcome the training deficiencies of the health workers are being published separately.

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## Acknowledgement

Four institutions namely, the National Institute of Health and Family Welfare, New Delhi, Ganghigram Institute of Rural Health and Family Welfare Trust, Gandhigram, Indian Institute of Management, Ahmedabad and Indian Institute of Management, Bangalore collaborated in this study. The seed money for this project was provided by the World Health Organisation, Geneva, and Dr. Dev Ray and Dr. A Hamad of the Divisions of Health Manpower Development and Strengthening of Health Services respectively had taken keen interest in this study. The principal investigators are grateful to the World Health Organisation and also to the Ministry of Health and Family Welfare. They are also thankful to the Directors of the four Institutes for the support provided by them during the study period.

A large number of officials and non-officials have helped in various capacities during the conduct of the study. They are:

- (a) Directors of Medical and Health Services of the State of Andhra Pradesh, Gujarat, Haryana and Karnataka.
- (b) Chief Medical Officers and their deputies of the districts of Anantpur and Chittoor in Andhra Pradesh, Panchmahal and Bharuch in Gujarat, Rohtak and Sonapat in Haryana, and Bangalore and Mandiya in Karnataka.
- (c) Medical Officers in-charge of the Primary Health Centres (PHCs) selected for the study and their staff spared their valuable time for extensive interviews and discussions with our staff. Many of them helped in providing accommodation, transport and such other physical facilities to the field staff during the period of data collection. The care with which the data were collected would not have been made possible but for the kind cooperation and assistance extended by each one of them.

The investigators gratefully acknowledge the kind cooperation of all of them.

The faculty and research staff of the four collaborating institutions have carried out the study despite constraints. The support extended and hard work put in by them deserve mention. The list of research staff involved in this study is given on the next page.

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There may be many others who have helped in numerous ways in this collaborative study. It is not possible to acknowledge their help individually but we take this opportunity to thank all of them. The authors are indebted to all for their services in the field and in the offices of the different collaborating institutions.



## Introduction

The Constitution of India lays down that every individual must have access to health care facilities, irrespective of caste or creed or socio-economic status. According to the Constitution, health is a State subject and responsibility lies with every State to ensure that health care facilities are equitably distributed.

The same dictum has been re-stated in the Alma Ata conference in 1978 with added emphasis. All member countries of WHO have declared 'Health for all by 2000 A.D.' to be the avowed goal and have resolved to take all possible steps to achieve this goal.

Since independence, the Government has been striving constantly to establish a proper health infrastructure for delivery of health care to the entire community. Based on the recommendations of the Bhore Committee, the initial step was to open primary health centres in the rural areas to serve as focal points from where curative and preventive services could radiate. Considerable progress has been made through the five-year plans to establish more and more primary health centres, and at present, a primary health centre in the country serves on an average one lakh (1,00,000) of population.

In the beginning, primary health centres were very meagerly staffed for want of financial resources and technical manpower. Today the staff position has been considerably augmented with facilities being made available for technical manpower training. In the sixties a number of single-purpose vertical programmes had been undertaken to eradicate or control certain major communicable diseases like malaria, smallpox, leprosy and tuberculosis etc.

In 1964, a system of basic health services was sought to be introduced so that all the vertical programmes could be integrated to offer to the community basic health care. For one reason or the other, this could not be implemented and vertical programmes continued as such.

In 1972, it was again felt that it would be more meaningful for the workers as well as community to integrate all the programmes. The Kartar Singh Committee recommended introduction of multi-purpose workers (MPW) scheme under which two multi-purpose workers (one male and one female) would be available for every 10,000 population immediately, and later two workers (one male and one female) for every 5,000 population; otherwise the multi-purpose workers would not be able to do enough justice for effective coverage. For promoting better community

participation, it was felt that a person from the community should take primary responsibility of being a link between PHC staff and the community and also function as a change agent. Therefore, a rural health scheme, in keeping with the recommendation of Alma Ata under 'Community Participation', was formulated under which one 'local' person for every 1000 population would be selected and trained to function as a community health guide.

However, the extent of under utilisation of the health care services continues to be wide and it needs to be overcome before making further addition of staff and facilities. Several studies, particularly those carried out by the erstwhile National Institute of Health Administration and Education, under the District Health Administration Research Project, identified management as the major weak link in the health care system. Lack of proper orientation of staff at different levels with regard to job functions relating to delivery of health care to the community has been repeatedly pointed out.

While doctors and para-medicals had received training in medical and health care, they were not exposed to management training, an essential training input for this purpose.

Attempts made by the National Institute of Health Administration and Education, now merged into the National Institute of Health and Family Welfare, to orient senior level health administrators to the principles of management through staff college courses, seminars and workshops have covered only a very small proportion of administrators. The majority of administrators in the health department have not yet had any training in managerial skills.

The scheme of orientation training for PHC doctors and para-medicals in the late fifties and early sixties was discontinued because of various constraints. With the introduction of the multi-purpose worker scheme, all the medical officers and para-medicals of those States, where the scheme was adopted and implemented, have undergone orientation training in the integrated approach. But, there too, the management aspects of planning, evaluation, material management, supervision etc. have not been sufficiently stressed.

The most essential requirement for achievement of 'Health for all by 2000 A.D.', through the primary health care approach is that every health functionary must know how to plan his/her work, how to evaluate, how to report, how to solve problems, how to coordinate and so on. Certain managerial capabilities have to be developed for each level of functionary depending on the job functions. It is appropriate and timely now to identify the training needs for strengthening the managerial skills and take necessary steps for the proper training of all categories of health personnel and thereby ensure that the available manpower and material resources are appropriately channelised and effectively utilised.

It has to be mentioned in this context that WHO have sponsored projects on health management training in a number of countries in this region. For India the seed money was given to the National Institute of Health and Family Welfare, New Delhi for undertaking this project.

In accordance with the wishes of the WHO and the Ministry of Health and Family



Welfare, Government of India, the NIHFW agreed to undertake this study. At the initial stage, a Steering Committee was formed with the following members:

Dr. M.D. Saigal, Deputy Director General (Rural Health), Ministry of Health & Family Welfare.

Mr. Vijay Bhushan, Dy. Secretary (International Health), Ministry of Health & Family Welfare.

Dr. L.H. David, Administrative Staff College of India, Hyderabad.

Dr. P.P. Talwar, Director, India Population Project, Lucknow.

Prof. N. Maru, Indian Institute of Management, Ahmedabad.

Dr. R.K. Sanyal, Director, National Institute of Health and Family Welfare.

Dr. R.S. Gupta, National Institute of Health and Family Welfare.

Dr. J.R. Bhatia, National Institute of Health and Family Welfare.

The Steering Committee took the following decisions:

- i. The PHC staff, mainly responsible for delivery of health care in the community have not had training in management. The concentration should, therefore, be on the PHC staff after their training needs are identified.
- ii. Development of training modules for all categories of health staff.
- iii. The modules should be tried out and their feasibility evaluated.
- iv. The time period for the project being a little more than a year, it was decided to take up the development of training modules for district and state level officers at subsequent phase, if funds permitted.
- v. The training modules should be prepared in as simple a manner as possible and should take the practical situation into consideration in regard to the health care delivery system. In other words, the training should be applied in the health field rather than in principles of management applicable to industries and public enterprises.

In order to ensure wider geographical coverage in the country and the use of widest experience in management, the NIHFW invited the following institutions in different regions to collaborate in the study:

Indian Institute of Management, Ahmedabad.

Indian Institute of Management, Bangalore.

Gandhigram Institute of Rural Health and Family Welfare Trust.

The study was taken up in two phases: (1) identification of the training needs and (2) development of training modules. This report, comprising 11 chapters, includes an introduction, the objectives and methodology of the study, a brief description of the organisational structure of the health system and the educational and training facilities in different states, the findings of the study in the diagnostic phase, the health management training needs for each category of worker at PHC level, the future line of action with regard to the development of training modules and their feasibility trials.





## Objectives, Methodology and Design

### OBJECTIVES

The study was undertaken with the following objectives:

*General:* The overall objective of this project is to promote effective and efficient delivery of primary health care in the country through strengthening of training programmes for various categories of health workers by improvement in the training contents related to the management aspects of the service delivery.

*Specific:* To develop training modules for different categories of health workers to ensure adequate training for management of operational problems in relation to primary health care programmes in India;

To prepare a plan of action for implementation of the training programme based on the above modules to ensure that all categories of health workers are covered by the training programmes.

### PHASING AND METHODOLOGY

The study was planned in two phases. In the first phase, the health management training needs of all categories of staff at PHC level (and below) were identified. The second phase is for the development of training modules for all categories of health staff in a PHC.

In order to identify the training needs the following four approaches were adopted:

Job analysis of the workers for indentifying the management component.

Collecting data through interviews on the functioning of the workers.

Participatory observation of the workers functioning to determine their role performance.

Organisation of a workshop for primary health centre, district and state level officers.

From the interviews and observations and also from the workshop a large number of issues relating to problems of management emerged. Some of these are amenable to change through management training of the workers and others would require policy

decisions and administrative actions. In the latter category were the issues like delegation of powers, lack of transport facilities, accommodation, delayed payments of salaries, inadequate travel and daily allowances (TA/DA), insufficient stationery or stores items etc. Such problems were listed down separately as requiring the attention of the higher authorities at the state level. Those problems which were amenable to improvement by suitable management training were separated out and are given in chapters V to IX of this report.

#### *Job analysis of the workers for identifying the management component*

In this approach, the job functions of different categories of workers were analysed to identify the areas where a particular category of worker would need management training and the form in which it was to be provided. It is possible that each job function has a component of management/organisation, and the worker should be trained to handle it efficiently.

#### *Collecting data through interviews on the functioning of the workers*

A detailed set of questionnaires had been developed to determine the job functioning style of each category of workers whose management training needs were to be assessed. These questionnaires, which covered various activities they were expected to perform, were directed to know (i) whether they performed those activities or not, (ii) if they did, what was the method used by them, (iii) if they did not, why was it so, and (iv) what could be done to make them perform their role in an efficient manner. Information was collected from all categories of workers working at PHC level or below. Attempt was thus made to identify the gaps in the performance of role functions of various categories of workers.

#### *Participatory observation of the workers functioning to determine their role performance*

In order to verify the responses given by the respondents, effort was made to observe the workers performing these activities. The interviewers spent a week's total work time with the workers. A checklist of functions to be observed was made. Based on this common checklist, different collaborating institutes had collected observations on important job functions on a uniform basis.

Information thus collected had dual purpose. Its comparison with similar set of information, collected through the questionnaire approach, helped to assess the accuracy of information so collected and to the extent information obtained was accurate, interpretation would be free of errors. Secondly, this approach supplemented the information collected through the questionnaire; it was particularly so for the quality of the job performance which different workers undertook.



### *Organization of a workshop for primary health centre, district and state level officers*

This approach offered another perspective to the health management training needs. The medical officers were asked to identify management problems in the delivery of the primary health care. The district and state level officers, who monitor and supervise the work of the PHC level workers, were asked to identify the training needs of the workers and suggest the type of training required. They were able to indicate management problems at their own level and link their own problems with those at the block level.

## **STUDY DESIGN**

The analysis job approach was carried out by taking job functions of workers at PHC level and below as prescribed by the Government. Management training needs were listed down for efficient performance of the job functions.

A selection of PHCs and sub-centres was made to constitute a multistage design of sampling. In the first stage, two districts in each state were selected, the criteria being (i) the districts should have multipurpose workers scheme (MPW) implemented, and (ii) one district will have good MCH performance and the other poor. The State Family Welfare Officer was approached to group the districts into good and poor MCH performance districts and then one district from each was randomly selected.

In the second stage of sampling, four primary health centres were randomly selected from each district selected in the first stage. The rural dispensaries in Haryana and Andhra Pradesh were also covered to know the referral system. The third stage was selection of three sub-health centres, which included one main centre of the PHC and two sub-centres drawn from among the PHCs selected in the earlier stage. From the area of each selected sub (health) centre two villages were randomly selected for covering Health Guides (HGs) and Trained *Dais* (Traditional Birth Attendants).

The districts covered in the study were the following:

<i>Andhra Pradesh</i>	<i>Gujarat</i>	<i>Haryana</i>	<i>Karnataka</i>
Ananthpur	Panchmahal	Rothak	Bangalore
Chitoor	Bharuch	Sonepat	Mandya

In order to identify the problems relating to different components of management of primary health care, a sample of health personnel of different categories were interviewed.

The following staff was interviewed from each district:

- 24 health guides (HGs)
- All trained *dais* in 24 village from which health guides were interviewed.
- 12 male multi-purpose workers (MPWs)
- 12 female multi-purpose workers (MPWs)
- All male and female supervisors in selected PHCs.

- f. 12 medical officers (MOs) of all PHCs and all MOs from the selected rural dispensaries in Haryana and Andhra Pradesh.

One PHC out of the four selected for interview was drawn out from each district for observation of the workers there for one full week. The experienced staff members would spend full working day with the staff allotted to them, and accompany them while visiting the field in the week under observation. They would record their observations on the checklist for the workers and also on the working of the primary health centre unit as a whole.

The workshop approach provided a common forum for PHC, district and state level staff. This was used to identify (a) management problems, (b) the management training needs of different officials and functionaries, and (c) their operational problems where management training could help. The three-day workshop was held at the National Institute of Health and Family Welfare, New Delhi in 1981.



## State Level Organisation of Medical and Health Services

Health being a state subject, every state has a ministry of health and family welfare with secretarial support. There is no uniform pattern for the implementation of the programmes at the state level. Where complete intergration of the programmes has taken place, there is one director of health and family welfare services assisted by additional, joint, deputy and assistant directors etc. according to the needs, resources and policy of the states.

In some states, the departments of health and family welfare are under two different directors. In some others, there are separate directors for medical education, medical services, primary health care, indigenous system of medicine, Employees' State Insurance and so on. There is no point in describing in full the absence of uniformity in the state level organisation for comparison. Directors are overall in-charge of the health organisation in the entire state and the officers in the directorate have both line and staff functions. In those states where there is a director of medical education, all the medical colleges and teaching hospitals come under the control of that director.

All the states are divided into districts for the convenience of administration. Under the British rule, revenue districts were formed for collection of taxes and maintenance of law and order and that pattern still continues.

There is no uniform pattern at the district level of health organisation in all the states. There may be one chief medical officer or district medical and health officer controlling all the health institutions in the district or there may be different district officers for health, medical services and family planning and so on. It is generally the responsibility of the district officers to organise and ensure implementation of all the health programmes through the health institutions under their jurisdiction.

Like the state level, the district officers are assisted by certain number of deputies and assistants according to the pattern laid down by the individual states.

In some states there is an intermediate tier between the state and districts called Division. There are officers designated as regional officers or divisional officers, regional directors, regional deputy directors, zonal officers etc., in those states. They have two to three districts under their jurisdiction and their role is merely coordination and supervision. In some state they have also the administrative control for which they are delegated with necessary powers.



Every state has a network of hospitals in urban and rural areas according to the pattern evolved over the years. There is, however, no uniformity of size, grade and location of hospitals in all the states.

As already mentioned, the hospitals are under the control of different departments in different states. They may be part of the medical services department or of the health and family planning department as a whole. Again, it is difficult to give full description of hospitals and the administrative linkages.

Next to district level, there is an administrative unit of blocks and there is generally a primary health centre looking after health and family welfare needs of the block. The number of primary health centres (PHC) in a block is dependent on its population, the norm is one PHC for every 1,00,000 population. With regard to the primary health centre there is a great deal of uniformity in all the states. Since financial assistance for establishing primary health centres came from the central government the states were obliged to adhere to the pattern laid down by the centre. The states are continuing to get partial assistance in the running of the primary health centres and full assistance in respect of certain programmes like MCH and family planning, malaria etc. Therefore, considerable uniformity has been maintained with regard to the structure and functions of primary health centre in all the states.

The primary health centre is the nucleus from which curative and preventive services radiate in the rural areas. One medical officer is posted as incharge of all PHC activities and one or two more medical officers are also posted for assisting and sharing the work. One of the medical officers is generally female to be exclusively incharge of the MCH and FP.

When the primary health centre was first started the staff position was meagre. Besides one medical officer, there were only one sanitary inspector, one health visitor and four midwives. With the introduction of a number of single purpose programmes a number of paramedical staff were added. Under the expanded family planning programme the staff structure was further expanded with one lady doctor, one block extension educator, one lady health visitor and one family planning male worker for 20,000 population and one auxiliary nurse midwife (ANM) for every 10,000 population.

After the introduction of the multipurpose workers scheme, the staff position has been strengthened to provide two multipurpose health workers (MPW) (one male and one female) for every 10,000 population and one male supervisor for every four workers. The situation is being further improved with the addition of one male and one female worker for every 5,000 population and one male and one female supervisor for every four workers. The primary health centres have a number of sub-centres at the rate of one for every 10,000 population with a goal of having one for 5000. (This goal for every 5,000 is already achieved in some states).

Recently the community health guide scheme has been introduced in some of the states under the recommendation and financial assistance of the central government. Volunteers from the community have been selected and trained for three months at primary health centre level to provide primary health care. The main function of the community health guide (male and female) is to serve as a link between the health infrastructure of the government and the community and to educate and help the



community to avail of the facilities provided by the government.

There is one health guide for every one thousand population. With the introduction of this scheme one more medical officer has been posted at the primary health centre for the purpose of training, control and monitoring of this scheme. The health guides are to be supported and guided by the multipurpose health workers and the supervisors.

Another functionary getting involved in the MCH programme is traditional birth attendant (*dai*). It is planned to train the *dais* properly so that they can provide better MCH services to their clients. It is envisaged that their number will be large enough to have one trained *dai* for 1000 population. After training, *dais* are also provided with a kit for better and aseptic deliveries.





## Organisation of Education and Training Programmes in the State

A number of training centres have been created at different levels to train medical and paramedical staff at different levels. They range from primary health centres, ANM training centres, lady health visitor training centres, health and family welfare training centres, district hospitals to teaching hospitals of medical colleges. Not only these training centres train the fresh trainees but expose others to periodic reorientation to programmes strategies etc.

### MEDICAL EDUCATION

The undergraduate and postgraduate medical education is provided by the medical colleges in the country. Each college has a general hospital and some specialised hospitals attached to it for the purpose of training. In the states under study, the availability of such institutions for medical education varied from 1 to 13 with total admission capacity of 150 to 1013 per year.

In addition to these medical colleges, based on allopathic system, medical education is also provided in traditional systems of medicine such as ayurveda, homeopathy and similar others. Institutions and their admission capacities in four states under study are given in table 4.1. Courses for medical technologists in areas like Radiology, ECG, Cardiology, Laboratory, etc. are also provided in the hospitals listed.

### NURSING EDUCATION

The colleges of nursing in the states provide the courses of 4 years' duration and award degree of B.Sc. in nursing. There is one nursing college each in Gujarat and Karnataka with admission capacity of 25 and 20 respectively. Andhra Pradesh has three such colleges with admission capacity of 75, whereas Haryana has no such college. The community health is very well integrated in the course curriculum to form a major thrust. Hence most of the B.Sc. nursing graduates find employment as teachers in auxiliary nurse midwife training centres.

In addition to these colleges of nursing there are schools of nursing attached to the teaching general hospitals. In Andhra Pradesh there are eight such nursing schools with 370 seats; in Gujarat, four schools with 250 seats, in Haryana five schools with

145 seats, and in Karnataka three schools. These schools conduct 3 to 3½ years course in general nursing and midwifery.

## PARAMEDICAL EDUCATION

The female supervisory cadre of health workers have to undergo a training of 2½ years duration in the health visitors training schools. There are 1 to 3 such schools in each state with admission capacity of 30-60 candidates per school. In addition to the full courses, the schools also provide short course of 6 months' duration for the auxiliary nurse midwives who have put in minimum of 5 years service.

The auxiliary nursing midwife course of 1½ to 2 years' duration is provided by ANM training schools mostly affiliated with the nursing schools, general hospitals or civil hospitals. Some of the schools belong to the government and some are run by voluntary organisations depending on the hospital with which they are attached. Andhra Pradesh has 14 such schools, Gujarat 28, Haryana 8 and Karnataka has 25 schools. The table 4.1 presents the details of number of ANM and LHV schools and the admission capacity in the four states under study.

The health inspectors/ sanitary inspectors receive training of 6 to 12 months duration in health/ sanitary inspectors training schools attached with the medical colleges. In the states under study, Haryana and Gujarat have only one such school each, whereas Andhra Pradesh has five and Karnataka seven.

## INSERVICE EDUCATION AND TRAINING

*Regional Level:* In addition to these regular professional education and training programme for the medical personnel, there are regional health and family welfare training centres in each state to provide inservice training to the medical and paramedical personnel working at various levels in the region. These centres are financed by the central government.

There are four regional health and family welfare training centres (HFWTCs) each in Andhra Pradesh, Gujarat and Karnataka, and one in Haryana State. The staffing pattern of the HFWTCs is as under:

- Principal HFWTCs
- Medical Lecturer-cum-Demonstrator
- Health Education Instructor
- Social Science Instructor
- Public Health Nurse Instructor
- Health Education Extension Officer
- Statistician
- Other Supportive Staff

These HFWTCs were originally called regional family planning training centres and were intended to provide training to the medical officers and the paramedical staff in family planning, MCH, demography, and communication. After the introduction of multipurpose workers (MPW) schemes and the community health workers (CHW)



(now called health guides) scheme, the main activities of the centre are to give overall 30 days' training to medical officers of the PHC and 75 days training to BEEs under MPW scheme. The HFWTCs also undertake short-term courses for PHC staff as and when required.

*PHC/Block Level:* At the block (PHC) level, the health assistants or health supervisors (male and female) are provided training by MO(PHC) and BEE for supervision under MPW scheme. Inservice training is also provided to the health supervisors, multipurpose health workers (MPWs) and village level functionaries. The medical officers of PHC run an eight-week course for MPW(Males) and six-weeks course for MPW (Female) with the assistance of BEEs (and health supervisors). Faculty support and A.V. aids are provided by HFWTCs. The multipurpose health assistants (supervisors), after undergoing six-weeks' course at PHC are sent to the HFWTC for a two-weeks' course on supervisory skills. The medical officers conduct a one-month course for *dais* and three months course for the health guides (HG) with the assistance of ANMs and health supervisors of their area.

The progress of the training programmes at PHCs and HFWTCs with regard to MPW scheme, HG scheme and *dais* training scheme in the four states under study is presented in Table 4.2.

Table 4.1

Number of Medical and Paramedical Education Institutions and Inservice Training Institutions in the State under Study (December-1980)

Institution	STATE			
	Andhra Pradesh	Gujarat	Haryana	Karnataka
1. <i>Medical Education</i>				
A. <i>Number of Medical Colleges</i>				
i. Allopathic system	8	5	1	13
ii. Ayurvedic system	3	9	3	8
iii. Homeopathic system	3	2	—	4
iv. Other systems of medicine	2	—	—	1
B. <i>Admission Capacity in</i>				
i. Allopathic system	911	675	150	1013
ii. Ayurvedic system	110	267	200	195
iii. Homeopathic system	155	130	—	260
iv. Other systems	80	—	—	N.A.
2. <i>College of Nursing</i>				
Number	3	1	—	1
Admission Capacity	75	25	—	20
3. <i>Health Visitors Schools</i>				
Number	3	2	1	3
Admission Capacity	140	120	N.A.	90
4. <i>Nursing School (General)</i>				
Number	8	4	5	3
Admission Capacity	370	250	145	N.A.
5. <i>ANM Schools</i>				
Number	14	28	8	25
Admission Capacity	535	608	134	695
6. <i>Health Inspector Trg. Schools</i>				
Number	5	1	1	7
Admission Capacity	500	100	N.A.	N.A.
7. <i>Other Training Institutions</i>				
Number	17	5	4	21
Admission Capacity	439	352	310	45
8. <i>Regional Health &amp; Family Welfare Centres</i>				
Number	4	4	1	4



Table 4.2

Progress of the Training of Personnel under the various Schemes in four States till 31-3-1982.

Category of Health Personnel Trained	STATE			
	Andhra Pradesh	Gujarat	Haryana	Karnataka
<b>A. MPW Scheme</b>				
MOs	980	345	379	2534
BEE	774	251	88	243
MPHS (Male)	1960	1243	608	2360
MPHS (Female)	1016	674	128	1913
MPHW (Male)	5761	4417	1857	8301
MPHW (Female)	4127	2837	1021	7201
Others (Male)	168	—	22*	—
Others (Female)	82	—	26*	—
<b>B. H.G. Schemes</b>	18923	18768	5671	1502
<b>C. Dai's Training</b>	44503	19167	7427	10217

\*Data as on August, 1982

Source: Health Statistics of India, Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of India.





## Management Training Needs of Medical Officers of Primary Health Centre

### JOB ANALYSIS

After the scrutiny of the job description of the medical officers, it was surmised that the management training will be required for the medical officers for the following functions/ activities:

- Assessment of health needs in the community for health planning.
- Organisation of the OPD—allotment of duties and tasks among the staff, and monitoring.
- Organisation of emergency services—assessment of emergency needs, planning and allotment of responsibilities and monitoring.
- Organisation of laboratory services—assessment of needs and allotment of resources and monitoring.
- Guidance to health workers/health assistants and health guides in the treatment of minor ailments—in-service training and monitoring.
- Cooperation and coordination with other institutions providing medical care in the block—identification of such institution and establishing relationship for coordinated work.
- Planning and conduction of supervision of the staff and field visits—techniques of supervision, monitoring and reviewing.
- School health programmes—programme planning and implementation.
- Control of epidemic outbreaks—epidemiological techniques, resource mobilisation and plan of action.
- Village health guides—community organisation, selection of leaders and communication.
- Liaison with block development staff—inter-organisational cooperation.
- Health education—principles and methods of health education.
- Training—educational methods.
- Management of equipments and supplies—material management.
- Management of transport—transport management.
- Allotment of programmes to staff—programme planning, daily plan, weekly plan and monthly plan.
- Records and reports and returns—management information.

Review meeting.  
Day-to-day administrative correspondence etc.—office management.  
Financial dealings—financial management.  
Referral system.

## FINDINGS OF THE SURVEY

For this study a total of 89 medical officers in 40 PHCs were interviewed, 40 of them were incharge of PHCs and 49 were other medical officers. The sample consisted of 23 MOs from Karnatak, 28 MOs from Andhra Pradesh, 18 MOs from Gujarat and 20 MOs from Haryana. Although the same questionnaire was used for MO's incharge of PHCs (referred to as MO I/C in this report) and other MOs, their responses on some aspects differed. The report treats their responses as a whole. Similarly, an effort was made to pool the results of all the four states except for the cases where differences existed. However, a mention was made of the differences in opinion where ever such differences were significant.

### *Background information*

Most of the MOs were between 25 to 34 years of age; about 82 per cent were male and 85 per cent were married. Most of them were Hindus; 3 were Muslims and other 3 were Sikhs. About 87 per cent were serving in their own home states. In Karnataka and A.P, all were in their home state; in Gujarat and Haryana some doctors were from other states. About 55 per cent were brought up in urban areas and 35 per cent had both rural and urban background.

Most of the medical officers (81 per cent) had M.B.B.S. degree. About 14 per cent had acquired higher degrees such as Ph.D., M.D., or M.S. Another 5 per cent had Diploma in Child Health or Diploma in Obstetrics and Gynaecology. All of them had some work experience; however, the number of years of experience varied widely. About 34 per cent had 4 to 6 years of experience. Some of the MOs were promoted from dispensaries or other equivalents.

### *Training in rural health services*

Only about 40 per cent of all MOs had received some orientation towards rural health services. Only in Gujarat no MO had received such orientation training.

Asked about whether the orientation to the rural health services was needed 73 per cent of the MOs replied in the affirmative. The areas cited for further training were administration, reorientation towards family welfare including MCH and updating of medical knowledge (Table 5.1). However, most of them could not elaborate much on the content of reorientation or of the duration for such training. About 15 per cent of all MOs felt that the duration of reorientation training should be two weeks, while another 15 per cent suggested that it should be of four weeks. There was also a wide variety of suggestions about frequency of such orientation training ranging from once in a year to once in three years. About 12 per cent of MOs, however, wanted that such training is needed only once.



## *Work area*

Thirty-six per cent of MOs incharge were working in PHCs having less than 1,00,000 population and another 58 per cent were in PHCs having population between 1,00,000 and 1,60,000. About 50 per cent of all PHCs had 90 or more villages and about 30 per cent had less than 50 villages. About 4 of the 37 PHCs had less than 10 sub-centres, 21 had 10 to 19 sub-centres and 12 had more than 20 sub-centres. Thus the work areas of MOs showed considerable variation in size (Table 5.2).

Only two of the 40 PHCs had one medical officer. About 58 per cent PHCs had two MOs, 25 per cent PHCs had three MOs and the remaining 12 per cent PHCs had four MOs. Only about 27 per cent PHCs had 5 or less supervisory staff and less than 20 field staff. Nearly half the PHCs had 6 supervisory staff and the number of field workers varied between 21 and 40.

## *Health problems and needs*

Among the problems perceived by the MOs, the following are their ranking according to responses (Table 5.3)

Malnutrition	46 per cent
Malaria	33 per cent
Skin diseases	21 per cent
Water-borne diseases	20 per cent

A variety of health needs were indentified by the MOs. The important of these were health education, nutrition, sanitation, minor ailments, malaria, family welfare, water supply and 'more medical institutions', They had indentified these needs during their field visits (33 per cent), OPD experience (42 per cent) and from records (15 per cent). Group meetings and discussions or experiences of other personnel were used very infrequently. The role played by village leaders in assessing health needs, therefore, was minimal in all the states.

## *Planning activities*

By and large, MO I/C reported using the directions/guidelines received from higher levels to implement different programmes. More specifically, the targets for family planning and malaria programmes were mentioned by about half of all MOI/Cs. A few also mentioned receiving directions for school health and immunisation schedule. The MO I/Cs concentrated on working out details of implementation. But this largely consisted of distribution of targets for family planning and other work to the staff. About 20 per cent of MO I/Cs reported planning for routine activities and about the same percentage reported consulting the workers while planning the work. A few reported planning for orientation training camps.

They were, in general, not clear about the nature of planning at lower levels. About 30 per cent of them felt that workers had already been consulted while planning, and another 15 per cent felt there was little planning at lower levels.



### *Organization of work*

The responses of MO I/Cs on the question of how did they organise the work of PHC, differed and were not well articulated. About half of them reported that different MOs looked after different health programmes and the overall supervision responsibility rested with MO I/Cs and about 25 per cent said that OPD work was done by all the MOs and areas have been assigned to MOs for tour and supervision of the work.

The schedule of activities seems to have been drawn up by MO I/Cs according to the directions from the higher level, the convenience of the worker or the needs of the community.

However, most of the other MOs said that they followed directions from higher levels or of MO I/Cs. Their own convenience and workers' views on the needs of the clients were also considered in determining the schedule, as was mentioned by about 50 and 70 per cent of them respectively.

The MOs seem to follow routine schedules for visits to sub-centres. About 40 per cent of them said that workers' need determined the priority of the visits, while about 25 per cent said that priority was decided by convenience of the MOs.

However, when they were asked about the major consideration in planning visits to the sub-centres, a variety of such considerations emerged. These include needs of the area (60 per cent), possible returns of the visit (35 per cent) efficiency of the sub-centre (47 per cent) and solving problems of the workers (30 per cent). About 44 per cent reported that visits were routine so that all sub-centres should be covered (Table 5.4).

The visits to different villages were planned on the basis of needs of the area (73 per cent), possible benefit of the visit (53 per cent) and several other considerations.

Most of the MOs spent more than 11 days in PHCs and on an average less time in the field. About 15 to 50 per cent of MOs reported spending less than 11 days in the PHC. However, all days spent in PHC in the state of Karnataka.

On an average about 2 days per month were spent in meeting, but many MOs felt that this varied depending upon the circumstances. In Karnataka, quite a large number of MOs reported that they did not go to the field (Table 5.5).

The number of hours spent in the PHC clinic varied from three to eight hours, but 50 per cent MOs spent 6 hours. The average work load in OPD varied from one PHC to another; on an average about 100 new patients and 75 old patients were reported to be attending the clinics on any day.

Some of the major problems experienced by them in organising clinics include lack of transportation, staff, records and stationery, medicine, accommodation, audio-visual aids, sterilisation equipment, vaccines etc. Thus, in general, a considerable shortage of all facilities and supplies seems to exist in the PHCs, and the need for additional medicines, vaccines and sterilisation equipment should be specifically noted (Table 5.6).

Most of the MOs referred the cases, largely to district hospitals and, somewhat infrequently to medical college hospitals. Most of these cases were with surgical problems, serious injuries and difficult labour.



### *Sub-centre clinics and field visits*

Only about 18 per cent of MOs reported being able to visit weekly clinics at sub-centres regularly. These were quite large in A.P. and none in Karnataka. When asked about the reason for being unable to visit the sub-centres, transport problems and higher work load were mentioned as the main reasons (Table 5.7). The number of hours spent at the sub-centre clinic varied between less than one hour to more than 5 hours with an average of 2.7 hours. The time spent in the clinic depended upon the number of patients at the clinics. A variety of patients come to the sub-centre clinic but majority of them are emergency or complicated family planning cases, followed by those who wish to receive ante-natal and post-natal care.

Apart from providing services at the clinics, most of the MOs (above 60 per cent) reported checking of records, helping with returns, giving training to the workers and discussing maintenance of sub-centre etc., during their visits. About 37 per cent MOs suggested more transport facilities and medicines for making sub-centre visits more fruitful. More regular visits, prior information about sub-centre visits to the people, cooperation from the community were some of the other suggestions in this regard (Table 5.8).

### *Supervision*

About 60 per cent of all MOs responding said that workers accompanied them during their visits to the field for supervision. About 40 per cent of them stated that they spent more than 6 hours in field for supervision. Asked about whether the field workers had prior knowledge about their field programme, about 60 per cent replied in the affirmative.

The percentage of MOs mentioning different supervisory activities performed by them are shown below :

Checking the work and records of workers	88 per cent
Discussing sub-centre problems	62 per cent
Giving services to clients/complicated cases	58 per cent
Meeting the village leader for their cooperation	58 per cent
Checking drug distribution	8 per cent

The MOs were asked how did they assess the performance of the workers. They stated that it was largely assessed by checking records. (57 per cent), by concurrent checking of work (35 per cent), and by contacting the village community (39 per cent).

In reply to question what instruction did they give to the field workers and supervisors, 17 per cent MOs advised workers to follow strictly their tour programme; 29 per cent asked workers to visit 50 to 60 houses daily, 25 per cent asked for giving importance to family planning cases and 14 per cent asked for malaria control work and 20 per cent instructed them to work according to the needs of the area, 15 per cent asked them to give guidance to the junior. The main instruction given to the supervisors was to provide help in solving problems of the workers and to guide them. About 30 per cent of MOs, however, said that they did not give any instructions to supervisors (Table 5.9).



Among the methods suggested by the MOs to workers and supervisors for full coverage of children, keeping proper records, maintaining sufficient stocks of medicines, educating the parents, seeking help from supervisors and the community were important. Again about 28 per cent of MOs did not give any instructions. Similar methods were also suggested for completing the doses of immunization. In addition, team work and house visits were also mentioned for this purpose.

Most of the MOs stated that they had instructed the workers to supply contraceptives regularly to the users but did not suggest how this would be done. According to 50 per cent of the MOs, field visits and records and reports were the main ways of ensuring that the instructions were being followed.

Several difficulties were stated by MOs in their being able to supervise the staff including lack of transport and POL (50 per cent) and shortage of staff (21 per cent).

### *Coordination with HGs and Dais*

About 28 per cent MOs reported no cooperation in the work of HGs and programme workers. Instructing workers to take HGs with them on field visits and seeking their help in camps were the two main tasks of building cooperations with HGs according to most MOs. However, only 2 PHCs reported getting full cooperation and the remaining stated only partial cooperation. In reply to question about how the cooperation could be built between the workers and HGs, about 15 per cent MOs said that the workers should give more importance to HGs and help them in their problems.

The main ways of cooperation with *dais* were in taking their help in various programmes, and in supplementing their efforts. MOs felt that the cooperation between *dais* and programme personnel could be increased in various ways: with more incentives or stipends (34 per cent), setting joint targets (15 per cent) and by extending help through ANMs (12 per cent). However, about 15 per cent of all MOs did not make any suggestions to this end. MOs felt that they could help in strengthening the cooperation by providing guidance and instructing workers to contact them more frequently.

### *Community involvement*

Only about 12 per cent of MOs reported no community involvement, the remaining reported involvement of the community. However, the extent of community involvement varied. The community was reported to be involved in a passive role through orientation training camps (18 per cent), and in participating in group meetings and discussions (24 per cent). Active involvement of the community was sought through *Panchayats* (12 per cent), use of satisfied acceptors of family planning for family planning motivation work (9 per cent) and using them as depot holders (6 per cent).

The methods used for involvement of community include orientation training camps (32 per cent), personal discussions (28 per cent), health education (21 per cent), arranging exhibitions and cultural shows (16 per cent), and through village leaders (14 per cent). Their appointment as depot holders also involved them in the programme.



They could not suggest any new methods for increasing community involvement and suggested more frequent use of the same methods.

### *Coordination with other agencies*

About 38 per cent of the MOs said that there were no other agencies in the area involved in educational activities in health and family welfare. The remaining MOs mentioned a variety of other organisations including *Mahila Mandals* (24 per cent) and *Panchayat Samities* (11 per cent) and youth organisations (11 per cent). A few also mentioned Lions Club, adult education, youth organisations, school teachers, and health committees. Their percentage varied from 8 to 10 per cent. About half of the MOs did not make any efforts to coordinate the activities of these voluntary organisations and health workers. Wherever such efforts were made, these were largely made by MOI/Cs. Other MOs, *Panchayat* members or other officials were involved very infrequently. The efforts made to coordinate these activities took the form of discussions on health problems, identifying health needs and seeking agencies' help.

Most of the MOs stated they did not coordinate their activities with private health service facilities and practitioners of indigenous system of medicine. Wherever such coordination was sought, it was largely for family planning, discussion of health problems and epidemic control. Understandably, therefore, no specific methods for such coordination were mentioned by MOs and they also could not identify ways of bringing about better degree coordination than what existed.

### *Review/Staff meetings*

Monthly meetings were organised at all PHCs. In 61 per cent of the PHCs there were 1 or 2 meetings in a month and another 12 per cent PHCs had three monthly meetings. The distribution of hours of meetings varied as follows:

No. of hours	MOs reporting (in percentage)
1—2	6.5
2—3	13.0
3—4	29.8
4—5	14.3
5—6	23.4
6+	13.0

Average was about 4 hrs.

The topics generally discussed at these meetings include review of work and achievement of all programmes (85 per cent), problem of workers (52 per cent) and their evaluation (28 per cent), planning for future (35 per cent), and discussion of circulars and instructions from higher levels (28 per cent).

### *Performance of and relationship among PHC staff*

About 59 per cent of the MOs were satisfied with the performance of their field staff, 5 per cent were partly satisfied and the remaining 36 per cent were not satisfied. They felt that workers ought to conduct home visits according to the programme, carry out regular family surveys to know health problems and do immunization work, family planning motivation, and health education.

The responses of MOs on how the work of the field workers could be improved varied. Each of the following ways was suggested by about 15 per cent of the MOs—increase in administrative power of MOs, regular and strict checking of work, adequate transport facilities, incentives for good work and punishment for poor work, proper supervision, provision of accommodation, and reduction in work area.

The MOI/Cs were asked about satisfaction with the work of other MOs. About 96 per cent stated they were satisfied with the work of MOs. All medical officers were further asked about satisfaction with the work of their supervisors and 86 per cent reported being satisfied.

Except for one PHC, MO I/Cs felt that the other MOs cooperated with them. Most MO I/Cs and other MOs felt that supervisors should concentrate on their supervisory and guidance activities. The following important ways of improving the work of MOs and supervisors were indentified by them:

Transport facilities	20 per cent
Training	17 per cent
Supply of medicines	16 per cent
Disciplinary action against defaulting ones	11 per cent
Team work	11 per cent

### *Training activity*

The types of training programmes organised at PHCs included training for *dais* and HGs, and orientation training camps for staff and leaders. The training for multipurpose workers was also being organised at PHC level.

In most cases the training was organised in response to the directives from higher authorities. However, in rare cases, these were also organised on the basis of requests from workers, other senior staff members and the assessed need for training.

The main problems faced in training was shortage of accommodation (39 per cent), other physical facilities (18 per cent), and lack of funds (24 per cent). A few also mentioned lack of suitable trainers. MOs tried to make local arrangements and to adjust according to the means available to overcome these shortages.

About 80 per cent of all MOs felt that the training of various functionaries *i.e.*, the BEEs, health assistants and health workers, was adequate. Consequently, only reorientation training was suggested.



## *School health*

About 80 per cent of the MOs stated that school health programmes were to provide health education and services to school-going children with primary focus on immunization but would also include nutrition, environmental sanitation. The wide variety of responses on methods of planning of school health programme were not well specified. About 20 per cent of MOs felt no need for such planning. The strategy used primarily was to visit the school at least once a year and carry out a medical check up. Almost all MO I/Cs said the visit had to be used to give immunization to children through a team of workers. The children requiring further check up were referred to PHCs. The supervisory staff was sent to school to talk on health, nutrition and environmental sanitation.

About 50 per cent of the MO I/Cs stated that one teacher from each school was trained in health. However, the MOs suggested that effective training of teachers was needed for improving school health programme. More frequent visits to schools and assigning a medical officer exclusively for school health were some of their other suggestions in this respect.

## *Camps*

About 90 per cent of the MOs reported to have participated in multipurpose mini-camps and most of them found them useful. The main uses of camps as stated by them were that they provided an opportunity for educating the people about health activities (35 per cent), generating involvement of the community (12 per cent), carrying out immunization (13 per cent), and motivating people for adopting family planning methods (13 per cent).

The medical officers were asked about how to improve upon the camp activity. About 32 per cent said that camps should be organized more frequently and 29 per cent suggested involvement of local people in it. Other mechanisms suggested to make the camps more useful included prior information to people, and provision of curative services at these camps. They suggested that necessary publicity should be done well in advance and all types of services should be provided. Beyond these measures, most of them did not have any specific suggestions. No suggestions were made as how to strengthen follow-up services of the camps, except suggesting utilisation of workers for follow-up services.

## *Recording and reporting*

According to the MOs the following records are kept at PHC clinic—OPD register, indent stock register, ante-natal register, immunization register, malaria records, family welfare records, drug-dispensing register, and birth and death register. However, a wide variety of other records (*i.e.*, targets and achievements, leprosy, complaint etc), in all numbering more than 20, were also mentioned in a few PHCs. A variety of returns were received from sub-centre level comprising of MCH, family planning, malaria and vital events. In Integrated Child Development Services (ICDS) areas, *Balwari* reports were also received. Most (90 per cent) of the PHCs reported receiving



regular report from sub-centres. Remaining 10 per cent of MOs said that they would give warning to the person concerned if the reports were not received in time.

The reports received from sub-centres were used in the monthly meetings for assessing the progress (48 per cent), planning of future programmes (32 per cent), and sending the reports to district-level (45 per cent). Only one PHC explicitly reported using these records for indentifying reasons for non-achievement of targets. Although there seemed to be a general pattern in recording and reporting system, some local variations existed.

About 60 per cent of MOs reported checking of family planning, immunization, malaria and MCH reports in the monthly meetings. However, only 30 to 50 per cent reported reviewing health education, chlorination of wells, environmental sanitation, and school health programmes.

Usually the clerk or computer prepared the report to be sent to the district. Most PHCs sent the report monthly. However, about 10 per cent of the PHCs sent epidemic and malaria reports more frequently.

### *General perceptions*

The MOs were asked about their functions in PHCs. The responses of MO I/Cs differed from those of other MOs. Almost all MO I/Cs specified their functions as follows: administration, provision of curative services and preventive services, and coordination of various health services. More than 50 per cent also reported in-service training and arrangement of educational activities as their functions. In contrast to this, most of the other MOs specified curative services as their function. The next most frequently reported was preventive services. More than 45 per cent of the other MOs also specified one or more of the following functions: coordination of various health services, in-service training and arranging educational activities. Only about 43 per cent of other MOs at PHCs were involved in administrative activities (Table 5.10).

About 70 per cent of all MOs were satisfied with their work. The major reasons for dissatisfaction included insufficient supply of medicines (40 per cent), transport problem and inadequate POL budget (25 per cent), a lack of investigative facilities at PHCs (22 per cent), accommodation problems (25 per cent) and a lack of cooperation from workers (18 per cent). It is interesting to note that while about 10 per cent of dissatisfied MO I/Cs mentioned political interference as a problem, none of them mentioned inadequate administrative power. On the other hand, a few MOs mentioned lack of administrative power as a reason for dissatisfaction.

A wide variety of suggestions were made by the MOs for improving their present work. Increase in medicine supplies and better transport facilities were suggested by almost all. About half of the MOs dissatisfied with their work suggested one or more of the following: increased administrative powers, residential facilities for MOs, better investigative facilities at PHCs, proper water and electricity facility at PHCs, and more training.

A large number of those who felt performance of the programme as being not upto the expectation, mentioned illiteracy and ignorance of the people and meagre basic



facilities for the staff as the reasons. Lack of medicine, staff and transport were also mentioned by a few MOs.

About 50 per cent of all MOs felt that the services provided by the Government units were not satisfactory to the people. Lack of medicine and people's desire for more and quick services was mentioned by 90 per cent of such MOs as the reason for dissatisfaction. About 40 per cent of such MOs also mentioned lack of various facilities at PHC and high expectations of the people as reasons. The medical officers, in general, felt that people expected medicine and all other facilities at PHCs, more and quick services at their homes, availability of doctor at all times and prompt relief. The MOs also felt that as they paid for services from non-government units, they got quick attention and services. A few MOs also felt that people's expectation decreased when they went to non-government units.

Supply of good quality medicines in adequate quantities and increased awareness of education about health needs were the two measures suggested for increasing the popularity. More rapport between the MOs and other PHC staff and the people, community involvement, increase in literacy status and the use of curative services as a base for preventive services were some of the other mechanisms suggested for improving the situation.

## MANAGEMENT TRAINING NEEDS

### *Implications of survey findings*

After conducting the interviews and observations with medical officers of PHCs several areas were identified as management training needs. These are listed below:

- Orientation of the fresh recruits for rural health services.

- Reorientation with focus on management of the PHC—office administration.

- Assessment of health needs of the community.

- Management of clinics—allotment to duties and monitoring staff in the clinics.

- Orientation for knowing the job descriptions of all staff in the PHC.

- Planning the PHC activities—allotment of work and time scheduling for self and all field staff (this includes planning of medical officers visit to the sub-centres and field.)

- Supervision

- Organisation of team work, whenever necessary.

- Conduct of staff meetings—review and planning and problem solving.

- Maintenance of records, preparation of reports and returns—utilisation of reports for monitoring, evaluation and planning.

- Personnel management—human resources management.

- Coordination and cooperation with other agencies.

- Community—organisation.

- Community—within the health system and outside the health system.

- Management of school health programmes

- Management of camps

- Organisation of effective referral system

Apart from the above, there were certain other issues which required to be looked into by the health department for improving the functions of the PHCs. These are:

Budgetary provision

Financial powers

Disciplinary powers

Supplies of drugs, equipment, stationery etc.

Maintenance of transport

Technical guidance from districts and hospitals—through meetings and seminars, books and journals etc.

Work book or manual on community diagnosis to be prepared for use by the medical officers.



**Table 5.1**  
Need for re-orientation for rural health services

Type of orientation needed	Distribution of respondents				
	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
1. Training in field work	2	—	1	—	3 (4.6)
2. Administration	8	11	—	—	19 (29.3)
3. Training in Family Planning	6	6	—	—	12 (18.5)
4. Training in MCH	1	—	—	7	8 (12.3)
5. PHC activities	—	2	—	—	2 (3.1)
6. Updated Medical knowledge	3	2	2	9	16 (24.6)
7. Nutrition	—	1	—	—	1 (1.5)
8. Immunisation	—	1	—	—	1 (1.5)
9. Communication skill	—	1	—	—	1 (1.5)
10. Supervision	—	—	—	7	7 (10.8)
11. Others	3	2	—	—	5 (7.7)
Total Respondents	21	18	3	23	65

*Note:* (1) Multiple responses.

(2) No need for training was felt by 24 (27%) medical officers from Haryana and A.P.

(3) Figures in parenthesis indicate the percentages.

**Table 5.2**  
Distribution of Primary Health Centres by population, villages and number of sub-centres.

Population ('000)	No. of PHCs	No. of villages	No. of PHCs	No of Sub-centres	No. of PHCs
<80	6	< 50	11	< 5	0
80—100	7	50—70	5	5—9	4
100—120	11	70—90	3	10—14	10
120—140	7	90—110	2	15—19	11
140—160	3	> 110	16	20—24	9
> 160	2	—	—	> 24	3
No data	4	No data	3	No data	3
Total	40		40		40

*Table 5.3*  
Health problems as perceived by them

Health Problems	Reported in different states					%
	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	
Malaria	9	5	7	8	29	32.6
Environmental Sanitation	1	0	3	4	8	9.0
Malnutrition	19	13	2	7	41	46.1
Skin Diseases	11	5	3	0	19	21.3
Communicable diseases	1	4	0	0	5	5.6
Water borne diseases	5	3	3	7	18	20.2
Anaemia among pregnant women	8	0	1	5	14	15.1
Family Planning	2	2	1	0	5	5.6
Leprosy	9	2	0	0	11	12.4
V.D.	0	0	1	0	1	1.1
Hook Worm	0	0	0	5	5	5.6
Respiratory diseases	0	0	0	1	1	1.1
Total Respondents	28	18	20	23	89	

*Note:* Multiple responses.



Table 5.4

Major considerations in planning visits to the subcentre clinics or field areas

Major Consideration	Visits to Sub-centre clinics					Visits to Field Areas				
	A.P.	Gujarat	Haryana	Karnataka	Total	A.P.	Gujarat	Haryana	Karnataka	Total
1. Needs of the area	23	4	14	6	47 (59.5)	24	13	13	8	58 (73.4)
2. Possible returns of the visit	16	4	7	1	28 (35.4)	17	18	7	0	42 (53.2)
3. Efficiency of a particular sub-centre	23	4	8	2	37 (46.8)	23	11	4	2	40 (50.6)
4. All sub-centres are to be supervised on routine basis	19	2	0	14	35 (44.3)	21	5	0	12	38 (48.10)
5. To solve problems of workers	21	3	—	—	24 (30.4)	23	14	0	0	37 (46.8)
Total respondents	28	18	20	13	79	28	18	20	13	79

Note: (1) Multiple responses

(2) Ten medical officers from Karnataka state were not visiting the subcentre or field areas.

(3) Figures in parenthesis indicate percentages.

Table 5.5

Number of days spent in PHC, sub-centres, field supervision and meetings in one month

No. of days in a month	Andhra Pradesh				Gujarat				Haryana				Karnataka			
	PHC	Sub-centre	Field work	Meetings	PHC	Sub-centre	Field work	Meetings	PHC	Sub-centre	Field work	Meetings	PHC	Sub-centre	Field work	Meetings
0	0	0	0	0	0	13	1	0	1	1	1	1	0	10	10	2
1	1	0	0	6	0	0	0	4	3	3	1	7	0	0	6	11
2	0	0	0	14	0	0	0	8	0	2	4	5	0	11	7	7
3-5	0	16	4	8	0	3	1	6	0	4	5	6	0	2	0	3
6-8	1	5	5	0	8	0	1	0	2	8	8	0	0	0	0	0
9-11	4	4	8	0	1	0	3	0	1	1	1	1	0	0	0	0
> 11	22	3	11	0	9	2	12	0	17	1	0	0	23	0	0	0
Total respondents	28				18				20				23			

**Table 5.6**  
Difficulties faced in organising the clinic

Difficulties	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	%
Transportation	24	13	2	18	57	64.0
Staff	19	11	2	10	42	47.2
Records/Stationery	21	3	2	13	39	43.8
Medicines	12	7	2	16	37	41.6
Accommodation	17	6	2	12	37	41.6
A.V. Aids	22	0	1	12	35	39.6
Sterilisation Equipment	14	4	1	14	33	37.1
Vaccines	10	3	4	10	27	30.3
Financial	17	2	2	5	26	29.2
Sterilised syringes, needles etc.	8	4	0	10	22	24.7
Availability of Contraceptives	9	1	2	0	12	13.5
Others	0	3	2	0	5	5.6
Total respondents	28	18	20	23	89	

*Note:* Multiple responses

**Table 5.7**  
Reasons for not being able to visit weekly clinics at subcentre

Reasons for not visiting	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Transport problems	15	10	9	10	44 (60.0)
Work load at PHC is more	0	0	5	0	5 (6.8)
Not getting time/ too much work load	1	5	1	14	21 (28.6)
No. of subcentres are more	3	0	2	0	5 (6.8)
Total respondents	18	15	17	23	73

*Note:* (1) Multiple responses

(2) 16 medical officers stated that they visited all subcentres clinics.

(3) Figures in parenthesis indicate the percentages.

**Table 5.8**  
Opinions to make their visits to subcentres more fruitful

Ways to make visit fruitful	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	%
More transport facility	4	10	6	13	33	37.1
Visit to sub-centre should be known to people	2	1	7	0	10	11.2
Increase in frequency of visits	5	0	4	0	9	10.1
More medicines are provided	18	4	2	11	35	39.3
Cooperation from community	2	0	3	0	5	5.6
Total respondents	28	18	20	23	89	

*Note:* Multiple responses.



*Table 5.9*  
Specific instruction to workers and supervisors about their work

Specific Instructions	Category of Workers	
	Field Worker	Supervisors
To visit 50—60 houses daily	26 (29.2)	—
To give importance to F.P. Work	22 (24.7)	18 (27.2)
To give priority according to need of the area	18 (20.2)	—
To visit HGs regularly in the field	14 (15.7)	—
To give guidance to juniors	13 (14.6)	20 (30.3)
To give importance to the malaria work	12 (13.5)	5 (7.6)
To stick to your tour programme	15 (16.9)	—
To contact Public regularly	7 (7.9)	1 (1.5)
Epidemic control	4 (4.5)	—
Health Education	4 (4.5)	—
Multipurpose kit to be maintained	4 (4.5)	—
Checking work of the workers	— —	4 (6.1)
Proper supervision	— —	6 (9.1)
Regular reporting	— —	5 (7.6)
Spot-check in the field	— —	4 (6.1)
Check work-schedule of the worker	— —	3 (4.5)
Total respondents	89	66

*Note:* (1) Multiple responses

(2) Specific instructions were not given by 23 medical officers to the supervisors about their work.

(3) Figures in parenthesis indicate the percentages.

*Table 5.10*  
Perception on their functions

Functions	Percentage of	
	M.O.I/C	M.O
Administration	87.5	42.8
Provision of curative services	87.5	100.0
Provision of preventive services	82.5	73.5
Coordination of various health services	72.5	55.1
Provision of in-service training	57.5	59.2
Supervision of field staff	12.5	2.0
Arrangement of educational facilities	55.0	44.9
Total respondents	40	49

*Note:* Multiple responses.





## Management Training Needs of Health Assistants of PHCs

### JOB ANALYSIS

After scrutiny of the job description of health assistants it would appear that management training may be required for the health assistants for the following functions and activities:

- Planning and scheduling of their work
- Thorough knowledge of the staff working under them
- Supervision
- Review and monitoring
- Cooperation and coordination with other institutions
- School health programme
- Community organisation
- Training

### FINDINGS OF THE SURVEY

A total of 156 health assistants (88 male and 68 female) were personally interviewed with a pre-designed schedule in 4 states, namely, Andhra Pradesh (43), Gujarat (52), Haryana (19) and Karnataka (42) for eliciting information regarding the role, role-perception, and difficulties and problems in carrying out their normal duties.

Besides the interviews two selected health assistants of each category were observed from each state for a period of one week.

The data thus collected through the personal interviews and the observations were linked and a detailed reports is discussed hereunder.

#### *Background information*

The average age of male health assistants worked out to be 42 years as against 35 years for the female health assistants (Table 6.1). The female health assistants were in younger age groups as compared to male.

All the male health assistants were married. Among the female health assistants 81.2 per cent were married, 16.7 per cent female health assistants were unmarried.

Eighty per cent (125) of the total health assistants belonged to Hindu religion. Of the remaining 9.6 per cent (15) were Muslims, 8.9 per cent (14) were Christians and 1.9 per cent (2) were Sikhs.

The data on the educational status of the health assistants revealed that around 74 per cent of both male and female health assistants had middle to higher secondary level of education. The other health assistants were above higher secondary level (Table 6.2).

It is generally presumed that the health assistants who had spent their growing years in the rural areas had an understanding of the rural people and would know the local dialect spoken by the rural population. Keeping this in view, the supervisors were asked about their home state and the area where they had spent their growing years.

Of the health assistants interviewed 89.10 per cent reported that they hailed from the state where they are working (native state). About seventy four per cent (65) male health assistants and fifty two per cent (35) female health assistants reported to have spent their growing years in the rural areas. About 60 per cent of the total female health assistants of Karnataka state had spent their growing years in the urban areas.

### *Professional training*

Many of the female health assistants had their basic professional training as lady health visitor whereas many male health assistants had undergone sanitary inspector's course as their professional training. It is, however, observed from the data that in states like Karnataka and Andhra Pradesh some of the male health assistants and female health assistants had not undergone any basic professional training like the course of sanitary inspector and lady health visitor.

### *Time elapsed since professional training*

About 16 per cent of the total health assistants had their professional training around 5 years ago. Another 21 per cent had their professional training over 20 years ago. The remaining (62 per cent) had their professional training around 5-20 years ago.

### *Earlier post held by health assistants*

Previous to the present positions as health assistants under multipurpose workers scheme, post like senior health inspectors, junior health inspectors, health assistants, malaria surveillance workers etc., were one or the other post which were held by most of the male health assistants. A majority of the female health assistants had also worked previously as lady health visitors and the remaining as auxiliary nurse midwives.

### *Work experience*

The data on the work experience of both the male and female health assistants reveal that around 85 per cent of them had more than 10 years' experience in the field of health and family welfare.

The duration of work experience as health assistants under multipurpose workers



scheme would vary from state to state depending upon the date of implementation of multipurpose workers scheme. However, it was generally observed that around 74 per cent of the total health assistants had more than two years of work experience in their present position as health assistants under multipurpose workers scheme.

## **INSERVICE TRAINING**

### *Type of inservice training*

The health assistants in general had undergone inservice training on more than one occasion under different health programmes. Replies on their last inservice training showed variations from state to state. It was observed from the data on some state like Karnataka that all the health assistants were trained in multipurpose workers scheme or in any one of the health programme like leprosy, family welfare programme etc., whereas around 43.5 per cent (10) of male health assistants and 35 per cent female health assistants of Andhra Pradesh had not undergone any inservice training at all. Further the percentage of inservice training given to the health assistants under the multipurpose workers scheme was comparatively lesser in other two states also.

### *Duration of inservice training*

The duration of the inservice training varied depending upon the type of inservice training under each programme—for example, family welfare training 1 to 2 weeks, health education training 1-4 weeks, leprosy training 5 to 7 days, multipurpose health workers training 2 to 9 weeks. As per the course curriculum developed by the Government of India, a training of 8 weeks for female health assistants and 10 weeks for male health assistants was to be imparted under multipurpose workers scheme.

### *Time elapsed since last inservice training*

The estimated average number of years elapsed from the last inservice training of health assistants works out to 3.4 years. It was also observed that around 73 per cent of health assistants had had their last inservice training more than two years ago. (Table.6.3)

### *Place of inservice training*

The place of inservice training for health assistants under multipurpose workers scheme as specified by the Government of India is at primary health centres for 6 weeks and in health and family welfare training centres for 2 weeks.

### *Perception about the adequacy of training and functions*

Family planning motivation, health education methods, supervision, better means of communication, malaria, maternal and child health etc. were the areas in which knowledge was gained. This was reported only by a very few health assistants of both male and female categories. It indicates that the health assistants were not clear in

their minds about their functions as multipurpose health assistants and how the training received by them had helped them in performing their functions. Hence, here is a need to examine the training courses conducted by the states in regard to the contents, duration and the programme. (Table 6.4)

## AREA OF WORK

### *Number of sub-centres and villages—Supervision*

The number of sub-centres and villages to be supervised by the health assistants depends on the size of population and topography of the area. It was reported by more than 90 per cent of health assistants that they covered more than 10 villages. It was almost a common phenomenon in almost all the states that a considerable number of health assistants had to cover more than five sub-centres.

### *Number of workers*

On an average health assistants have to supervise the work of five health workers. About 56 per cent of the health assistants had reported having supervised five or more health workers.

### *Time required for covering all the villages*

Around 85 per cent of the male health assistants reported that two or more months were required for covering all the villages in their jurisdiction, while 90 per cent of the female health assistants expressed the same view.

According to them, some of the reasons for requiring more time to cover their areas were as follows:

- a. The number of villages to be covered was large.
- b. More workers were to be supervised.
- c. The distance to the farthest village from the headquarters, according to 87.5 per cent of the male health assistants and 95.8 per cent of female health assistants, was more than 10 kms.
- d. Inadequate conveyance facilities to reach the worker's area.
- e. The place of residence of the health assistants would also have some effect on time required for covering all the villages. It could be observed that only about 20 per cent of both male and female health assistants were having their place of residence within their PHC jurisdiction.

## PLANNING AND ORGANISATION OF WORK

A detailed account of the health assistants' work pattern, including planning, organisation, supervision and coordination of various health activities and staff meetings etc. is given in the subsequent paragraphs.



### *Consultation for planning for supervisory work*

About 70 per cent of male and female health assistants have expressed that they had consulted their medical officers in planning their supervisory work. Consultation with other health assistants of the area or the concerned health workers or block extension educator or villagers etc. had been mentioned by some of the health assistants (Table 6.5).

### *Determination of clinic days in different sub-centres*

Attending of sub-centre clinic was the main concern of the female health assistants. The data on the determination of clinic days in different sub-centres by the female health assistants revealed that 77.9 per cent (53) of them were adhering to their fixed visits based on the primary health centre monthly review meeting. A very small percentage of female health assistants (8.8 per cent) follows no fixed schedule but determined the clinic days according to their own convenience and on the request from their workers. The data further revealed that eight female health assistants in Karnataka state were not attending the sub-centre clinic since there was no sub-centre.

### *Consideration in planning visits by supervisors*

Needs of the area, efficiency of the worker, routine visits, possible returns and to solve the problems of the workers were the major considerations reported by a small percentage of health assistants in planning their supervisory visit to the clinic. (Table 6.6)

### *Determination of priority of field visits to villages*

Only 45 per cent of health assistants have reported master plan as the basis for determining their priority of field visits to villages. Sometime deviations like family planning camps, carrying out immunization in team work etc., are one or the other priorities used for determining their field visits to villages (Table 6.7).

The above facts reveal that most of the health assistants are not effectively planning their supervisory visits. The observation visits also confirm the same.

### *Knowledge of workers' programme and vice-versa*

Ninety nine per cent of the health assistants are aware of the workers' programme. Around 60 per cent (94) health assistants reported their workers being aware of their supervisory visits.

### *Number of villages visited in a month*

Of the total 156 health assistants interviewed, 21.8 per cent (34) reported that they would visit 5 to 10 villages in a month; around 44.9 per cent (70) said they would cover 10 to 15 villages in a month and the remaining 33.3 per cent (52) health assistants reported more than 15 villages, ranging from 15-45 villages.

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### *Number of days spent in a week*

The data on the number of days spent in a week by the health assistants at the PHC, at the sub-centre and at the field or village is given in Table 6.8.

More than 50 per cent of both male and female health assistants had reported that they made one day visit in a week to the PHC. More than 32 per cent of male and female health assistants had expressed that they made more than 3 days' visit to their sub-centres. More than 70 per cent of both the health assistants had reported that they made more than 3 days' visit in a week to the field villages. On an average it was found that all the health assistants were spending 2 to 3 days in the sub-centre, 3 days in the field and one day in PHC in a week.

### *Hours spent in the field per day*

The reported data on the number of hours spent per day in the sub-centre by the health assistants on an average worked out to be 3.6 hours for male health assistants and 3.8 hours for the female health assistants. The corresponding average time spent by them per day in the field worked out to be 4.6 hours and 4.3 hours for male and female health assistants respectively (Table 6.9).

### *Adequacy of time spent*

About 40 per cent (35) male health assistants and 47.6 per cent (32) female health assistants reported that they were able to complete their work within the time spent by them. The remaining health assistants who had expressed that the time spent was not sufficient has said that longer distance of the villages, lack of transport facilities, larger number of workers to be supervised and heavy workload at PHC were the reasons for the inadequacy of time.

### *Number of days in a week at sub-centre clinic conducted by female health assistants*

A considerable percentage of female health assistants reported that whenever they visited any sub-centre during a week they conducted the MCH and FP clinic in the sub-centre. The average number of sub-centre clinics conducted in a month by the female health assistants was similar to the average number of days spent in sub-centre *i.e.*, three days in a week.

### *Desirable frequency of visit to the field*

A majority (62.2 per cent) of the health assistants had expressed that once in a week could be the desirable frequency of visit to the field. The remaining health assistants suggested fortnightly or monthly field visit.

### *Full coverage and full course of immunization*

The data on full coverage and full course of immunization yielded no response from around 12 per cent of the female and male health assistants. Sixty four per cent (100) male and female health assistants had reported no possibility of ensuring full coverage of immunization to children. Only a small percentage of the male and



female health assistants (23.7 per cent) expressed the view that full coverage of immunization to children was possible.

Only 25 per cent of male and female health assistants said that it was possible to ensure a full course of immunization to children; of the remaining 75 per cent expressed that it was not at all possible to ensure full course of immunization to children (Table 6.10).

#### *Methods of ensuring full coverage and full course of immunization*

The health assistants, who had reported full coverage and full course of immunization expressed one or the other of the following methods namely:

Health education to parents, planning for adequate supply of vaccines, maintenance of records and their verification, regular follow-up visits, assistance from HGs, teachers etc.

#### *Methods of dealing with complicated cases*

A majority of health assistants 79.5 per cent had expressed that they had referred the complicated and emergency cases to their PHCs. Giving first-aid, referring to Government Hospitals/ nearest private hospitals were reported to be one or the other methods of dealing with complicated and emergency cases. During the field observation, it was found that no referral system was being followed.

#### *Methods of dealing with case of fever and rash*

On the question of the methods of dealing with a case of rash and fever, a majority (86.4 per cent) of health assistants had expressed that they would notify to the medical officer PHC. Some of the other activities like isolation, treatment, disinfection, health education, registration have also been reported by a few health assistants.

#### *Advice given to persons and family members suffering from communicable diseases*

It was found that 82.7 per cent of both male and female health assistants were giving advice to the person and family members suffering from communicable diseases with regard to isolation of patients. Health education activities like sterilization of the utensils, clothes etc., were also reported by 48.1 per cent of health assistants. Advice with regard to immunization and environmental sanitation was also provided by about 30 per cent of health assistants.

There were non-medical supervisors promoted as health assistants, who were not trained in the activities related to communicable diseases. Hence they had to be trained in a way so that they could deal with situation with definite procedure.

#### *Organisation of nutrition and family planning education*

Forty three per cent (67) male and female health assistants had reported that they conducted group meetings on nutritional and family welfare aspects. Of the remaining, a very low percentage of male and female health assistants had reported

adopting one or other educational methods like educating mothers (35.9 per cent), demonstration on the cheap nutritious food preparation (24.4 per cent), distribution of pamphlets, displaying posters, and organizing exhibitions, film shows etc. This indicated that there was no regular and proper programme of health education. (Table 6.11)

During the field observation also it was found that sporadic attempts were being made by the health assistants to educate the community on nutrition. No proper methodology was followed. It was also observed that they gave overwhelming importance to the family planning programme compared to any other health programme. This might be due to more stress on the targets fixed by the higher authorities.

### *Referral system*

Health assistants reported that they sometime referred cases like tuberculosis and gastro enteritis either to PHC or to the nearby hospital. It was revealed by a few health assistants (10.2 per cent) that they referred family welfare cases who required follow-up services, difficult labour cases, leprosy cases etc. (Table 6.12). However, on observation there was no clear evidence of any referral system.

### *School health programme*

The knowledge of health assistants about the various activities under the school health programme was sought to be checked with replies from them describing their activities. Nearly 48 to 73 per cent of health assistants said that medical check up, immunization and health education were being covered under the school health programme. A few health assistants said that environmental sanitation and nutrition education were also included under school health programme (Table. 6.13).

Having planned the visit to the school, other action required to be taken, as stated by more than 75 per cent of the male and female health assistants, were medical check up, immunization and imparting health knowledge (Table. 6.14).

It was experienced by 30 to 45 per cent of health assistants that provision of nutritious food, training of teachers in the treatment of minor ailments, involvement of teachers and parents in school health programme and regular follow-up visits might improve the school health programme. Other suggestions like separate staff with equipments, drugs and vaccine for schools, proper maintenance of school health record were also mentioned by a few health assistants.

With regard to the planning activities for the school health programme, majority of the health assistants (more than 80 per cent) had reported that they chalked out school health programme in consultation with the medical officers and school authorities.

## **SUPERVISION AND GUIDANCE**

### *Purpose of supervision*

Regarding the purpose of supervision more than 60 per cent of the health assistants of



both the sexes had expressed the following:

Helping the workers in planning their activities properly, to check their records, to assess the quantity and quality of the performance of the workers and the job done by them. However, about 50 per cent of the female health assistants had expressed that one of their job functions was to insert IUD. With regard to the job function of replenishment of stocks, 54.4 per cent (37) female health assistants expressed that they were helping the workers in replenishment of stock; and 38.6 per cent (34) of male health assistants expressed the same (Table 6.15).

### *Aspects of the work supervised in the field and the clinic*

Around 53 per cent (91) of the health assistants reported that they checked the workers' diary and records when they went for clinic, whereas more than 49 per cent had expressed that they checked diary and records during their field supervision. The other aspects of the supervision like verification of health activities, checking of midwifery kits and equipments and ante-natal care examination had been reported by a less percentage of health assistants (Table 6.16).

This evidently showed that some of the health assistants were not fully aware of the various components of supervision.

### *Assessment of the performance of the worker*

Forty to fifty seven per cent of the health assistants (male and female) mainly relied on field verification and scrutiny of records and target achievement to assess the performance of the workers. Some of the health assistants asked the people in the community about the popularity of the worker (Table 6.17).

During field observation it was found that the supervisors were not using checklist for evaluation of the various activities of the workers. They needed training in various methods of assessment of workers.

Around 50 per cent of health assistants reported that they either checked the records or enquired from the people in the absence of the workers. Others had not properly responded to this question.

### *Activities performed for effective supervision*

The data on the activities performed for effective supervision both in the clinic and the field were not so encouraging. Only a few (about 20 per cent) had responded as doing the following:

- Giving health education,
- Verification of records, drugs and medicines,
- Follow-up of sterilization cases etc.

### *Specific instructions to the workers*

Regarding identification of the priority of health programmes, the health assistants

reported to have instructed the workers on family planning and immunization in about 45 per cent and 30 per cent of cases respectively; on identification of malaria, early diagnosis and control of communicable diseases and health education in 20 to 30 per cent of the cases (Table 6.18).

#### *Instructions regarding priority couples*

The health assistants, by and large did not know how to instruct the workers to identify priority couples. According to a few, the following were the instructions for identifying the priority couples; low socio-economic groups (22.4 per cent) willing cases (37.8 per cent), ante-natal or pre-natal cases (12.8 per cent) and house to house enquiry (10.9 per cent).

#### *Action to be taken for referral cases*

Nearly 60 per cent of the health assistants told that they instructed the workers to follow-up the referred cases.

#### *Instructions regarding educational activities*

Regarding the educational activities, the health assistants were asked how did they instruct the workers to this end. Nearly 40 to 50 per cent of respondents said that they instructed their workers to conduct group meetings and carry out health education. A few respondents also said that they instructed to conduct orientation training for teachers, leaders, HGs and trained *dais* (11 per cent), film shows (21 per cent) etc. However they did not seem to give any demonstration.

### **COORDINATION**

#### *Work relation of the field worker with the health guide and trained dai*

Around 49 to 55 per cent of the health assistants expressed that the relationship of the worker with the HGs and trained *dais* was good. Around 28 per cent and 35 per cent of health assistants opined as fair. Out of the remaining health assistants, 8 to 12 per cent expressed that the relationship of health workers with the HGs and trained *dais* was bad.

#### *Suggestions for strengthening the cooperation between the field workers, HGs and trained dais and the role of health assistants*

Supervisor plays a vital role in coordinating the activities of the workers, HGs and *dais*. In order to have effective cooperation between the workers, HGs and *dais*, the supervisors had suggested the following:

Instruct the workers to meet <i>dais</i> and HGs to get their help	(27.6 per cent)
Regular payment of honorarium, to trained <i>dais</i> and HGs	(19.9 per cent)
Enhancement of salary	(9.0 per cent)



Adivce to HGs and <i>dais</i> to help the worker	(12.2 per cent)
To get the problems of HGs and <i>dais</i> removed	(9.0 per cent)

Apart from the above suggestions a few health assistants suggested that providing technical guidance and giving required drugs, etc. might encourage them to extend their cooperation in health programmes.

### *Methods of involving the community in health service activities*

Health assistants (77) stated that they participated in community youth clubs, village *panchayat* meetings, 18 per cent (28) in 'conducting family planning orientation camps' and 9 per cent (14) stated 'conducting group meetings' as method of involving the community in health service activities. Over twenty per cent health assistants expressed that they involve community in health education, and 15 per cent work through satisfied adopters, and a very low percentage of health assistants mentioned taking help of HGs and trained *dais* and organisation of cultural programmes as some of the methods. It showed that the health assistants were not following a proper methodology for ensuring involvement of community in the health programmes (Table. 6.19).

However, there was a vast difference in the answers given by the health assistants. It would be better if they were reoriented in various methods of involvement of the community. In the field observation of health assistants it was learnt that except individual contact by the health assistants no other efforts of involvement of community were made.

## **STAFF MEETING**

To the question whether the functions of the HGs and trained *dais* discussed in staff meeting or not, 45.5 per cent (71) health assistants said they had discussed the assistance given by the *dais* and HGs to the health worker under family planning, immunization and in spraying work, while another 29.5 per cent stated that they discussed the assessments of work done. Around 15 per cent of the health assistants said that they discussed the help received from the HGs and *dais* in blood smear collection, maintenance of kit etc. Twenty four (15.3 per cent) health assistants said that they were not discussing anything about the HGs and *dais*.

## **SATISFACTION WITH THE WORK PATTERN**

According to the information furnished by the health assistants with regard to the performance of their workers, it was ascertained that about 68 per cent of health assistants, both male and female, were satisfied with performance of the workers. The remaining percentage of health assistants said that they were not satisfied with the performance of the workers.

### *Reasons for satisfaction*

The satisfied health assistants gave the following major reasons for their satisfaction

with the work of workers. Achievement of the targets by the workers, record keeping and regular field visits are said to have satisfied 74.4 per cent, 24.4 per cent and 31.6 per cent health assistants respectively.

### *Reasons for dissatisfaction*

The dissatisfied health assistants quoted the following major reasons for their dissatisfaction: achievements below the targets (64 per cent), irregular field visits (38 per cent), and improper record maintenance (26 per cent).

## **SERVICE SATISFACTION OF HEALTH ASSISTANTS**

With regard to the service satisfaction of health assistants, 67.3 per cent had stated to be satisfied with their service.

### *Reasons for dissatisfaction with service by the health assistants*

Among the dissatisfied health assistants 33.3 per cent, 23.5 per cent, 21.6 per cent, 15.7 per cent health assistants cited such reasons, inadequate transport facilities, inadequate supply of stationery, vast areas of supervision, insufficient travel allowances respectively for their dissatisfaction. The other reasons like accommodation difficulty, heavy work-load and absence of guidance, lack of cooperation etc. had also been given by a few health assistants.

## **RECORDS AND REPORTS**

All the health assistants were maintaining diary, but the type and extent of information recorded differed. Nearly three-fourth of the health assistants said that they recorded details of their work under different programmes such as MCH, FP, EPI, NMEP, nutrition etc. It also contained education programmes, drugs given etc. Since variations were there in the maintenance of diary, it could be suggested that uniformity in maintaining a diary might be stressed.

Regarding usefulness of the diary, nearly half of the respondents said that it was documentary evidence of their work, a tool to assess the quality of work and it was helpful for future planning. Nearly 18 per cent respondents added that they were preparing their monthly report, making follow-up of service using the diary.

### *Number of registers and returns maintained*

The number of registers to be maintained by health assistants differed with respect to their job responsibilities. Interview with health assistants showed that nearly 24 per cent of both categories (male and female) maintained more than 10 registers. Another 33 per cent of health assistants, both male and female, said that they maintained 7 to 10 registers. Four male and seven female health assistants said that they maintained only one register. It was learnt from the health assistants that they had not been supplied with printed registers for their programme.

Nearly 20 per cent of the health assistants stated that they submitted only one



return of their activities. Another 20 per cent of the male and 30 per cent of the female health assistants submitted 2 to 4 returns. It was interesting to note that the five male health assistants and two female health assistants said that they were submitting more than 15 returns (Table 6.20).

From their statement it was noted that nearly 10 per cent of the male health assistants and 8 per cent of the female health assistants were taking more than three hours per day to make necessary entries in their registers. Another 27 per cent of health assistants, male and female, said that they took less than one hour for this purpose.

Asked about the difficulties faced by them in maintaining their records and registers, nearly 30 per cent of respondents in both the categories revealed that they did not face any problems. About 30-35 per cent in each category said difficulties arose because of non-supply of printed registers or forms or stationery. Only a few health assistants mentioned of too much recording work.

With regard to the usefulness of the records and registers, 25 to 40 per cent health assistants said that it was a documentary evidence of their work, and could be used to assess the progress of work and plan for future. A few (13 per cent) said that it was useful for preparing monthly reports and follow-up services.

## PROBLEMS AND SUGGESTIONS

About 36 per cent of the health assistants mentioned problems such as large number of villages, lack of transport facilities to many villages in carrying out their work. Fifteen per cent reported unexpected changes in their advance tour programme as the problem.

### *Need and suggestions for effective supervision*

Better transportation facilities (37.2 per cent), supply of kit with medicine (28.2 per cent) proper design of area (24.4 per cent), supply of stationery (16.7 per cent), uniform TA and immediate payment (16.0 per cent) were some of the felt needs of the health assistants for effective supervision.

In addition, a few health assistants had suggested that the provision of audio-visual aids, appointment of women volunteer, cooperation of the workers, promotional opportunities, frequent and periodical inservice training, frequent visits of the medical officer to the villages were some of the ways to improve and strengthen supervisory activities of health assistants.

Transportation was a big problem because of lack of public transport facilities in remote villages.

In order to overcome these difficulties the health assistants were of the opinion that they should be given loan at subsidised rate for purchase of two wheelers, liberal travelling allowance, utilization of PHC vehicle for interior villages and improvement in public transport facilities.

### *Suggestion for improvement of the work of the worker*

The health assistants as the supervisors of the health workers, felt that reducing the

population allotted to each worker, regular supply of drugs and equipments, provision of residential quarters and sub-centre buildings, refresher courses at regular intervals, incentive for good work and punishment for not doing work, uniform TA, good salary etc. were some of the important suggestions for improving the performance of the workers.

### *People's attitude as perceived by health assistants*

The health assistants were asked about the attitude of the people in their area towards health and other family welfare services provided by them. Nearly 65 per cent of the health assistants, both male and female, said that the people were satisfied with the health and family welfare service programmes. The remaining respondents said that the people were not happy with the services provided.

### *Suggestions to strengthen health services*

To strengthen the health services, the health assistants had given a number of suggestions like supply of drugs for treatment of ailments (30.1 per cent), higher incentives for family planning adoptors (9.6 per cent), intensive health education (37.2 per cent), better follow-up services (16.0 per cent), involvement of other developmental and voluntary agencies, (7.6 per cent), limited area for workers and supervisors, weekly sub-centre clinic, regular and periodical inservice training, frequent visits by programme personnel etc.

## **MANAGEMENT TRAINING NEEDS**

### *Implications of survey findings*

The study brings into focus through interviews and observations of health assistants (male and female) the areas where health management training is needed to strengthen primary health care services. The areas are listed as under:

Supervision—knowing the work of workers to be supervised ; planning for supervision, principles and techniques of supervision.

Monitoring—qualitative and quantitative assessment of work.

Planning—planning of daily, and monthly activities of self and for the workers.

Coordination—coordinating the multipurpose health workers with HGs and *dais*—coordination with block staff.

Community organisation—principles and methods.

Referral system—to and from referral services and follow-up.

Use of visual aids in educational activities.

Leadership for supervision, coordination and community organisation.

In addition to the areas mentioned above the department will be required to look into other issues simultaneously for improvement of the services. These are given below:

Allotment of compact areas for supervision.



Restricting the number of sub-centres to four as recommended under the MPW scheme.

Filling of vacant posts.

Availability of accommodation for sub-centres and for staff quarters.

Adequate supply of drugs.

Adequate supply of stationery and printed forms and reports

Uniformity of records and reports.

Supply of kits for health assistants.

Advance payment of T.A.

Proper transport facilities.

Table 6.1

## Age sex distribution of Health Assistants

Age (Years)	Andhra Pradesh		Haryana		Karnataka		Gujarat		Total			
									Male		Female	
	M	F	M	F	M	F	M	F	No.	%	No.	%
20-24	—	—	—	—	—	—	—	1	—	—	1	1.5
25-29	1	2	—	1	1	5	1	6	3	3.41	14	20.6
30-34	2	7	3	3	1	11	2	6	8	9.09	27	39.7
35-39	7	5	3	1	1	2	6	4	17	19.32	12	17.6
40-44	11	4	5	2	4	2	20	2	40	45.45	10	14.7
45-49	2	2	1	—	5	1	1	—	9	10.23	3	4.4
50	—	—	—	—	9	—	2	1	11	12.50	1	1.5
Total	23	20	12	7	21	21	32	20	88	100.0	68	100.0

Note: M—Male F—Female

Table 6.2

## Educational status of the Health Assistants (M &amp; F)

Educational Status	Andhra Pradesh	Haryana	Karnataka	Gujarat	Total	
					No	%
Above Primary to Middle	1	—	—	2	3	1.9
Middle to Higher Secondary	41	14	37	23	115	73.7
Above Higher Secondary to College	1	4	4	26	35	22.4
Above College degree	—	1	1	1	3	1.9
Total	43	19	42	52	156	100.0

Table 6.3

## Distribution of Health Assistants by the time elapsed since the last inservice training

Time elapsed in years	Andhra Pradesh	Haryana	Karnataka	Total	
				No.	%
No Training	—	2	—	2	1.9
< 1	—	1	5	6	5.8
1-2	8	1	11	20	19.2
2-3	8	2	12	22	21.1
3-4	4	5	6	15	14.4
4-5	3	4	4	11	10.6
> 5	20	4	4	28	26.9
Total	43	19	42	104	100.0

Note: Frequency data not available for Gujarat State but modal value is 2 years and range 1 to 9 years.



Table 6.4

Health Assistants that perceived adequacy of inservice training in terms of areas of knowledge gained

Areas of knowledge gained	Andhra Pradesh	Haryana	Karnataka	Gujarat	Total
Family Planning Motivation	21	—	4	12	37 (26.2)
Expanded programme of Immunization	13	2	1	6	22 (15.6)
National Malaria Eradication programme	10	—	8	6	24 (17.0)
Epidemic Diseases Control	3	—	3	4	10 (7.1)
Treatment of minor ailments	5	1	3	4	13 (9.2)
Health Education Methods	12	2	1	9	24 (17.0)
Nutrition Programme	6	—	2	4	12 (8.5)
BCG Vaccination	5	—	6	8	19 (13.5)
Environmental sanitation	4	—	—	6	10 (7.1)
Knowledge in MPW Scheme	—	—	15	14	29 (20.6)
Able to identify leprosy	—	—	10	—	10 (7.1)
Health Hazards and Food Adulteration Act.	—	—	2	—	2 (1.4)
On supervision	11	—	5	7	23 (16.3)
In all health programmes	—	—	2	—	2 (1.4)
Better means of Communication	15	—	1	5	21 (14.9)
Communicable diseases	3	—	—	—	3 (2.1)
Orientation training camps	3	—	—	—	3 (2.1)
Register maintenance	—	—	1	—	1 (0.7)
Not useful	—	—	2	—	2 (1.4)
Not gained knowledge	1	—	—	9	10 (7.1)
Total	38	17	40	46	141

Note: (1) Multiple responses

(2) In all, 15 Health Assistants did not respond to the question.

(3) Figures in parenthesis indicate percentages.

Table 6.5

Consultation sought for planning of supervisory work by Health Assistants

Consultants	Andhra Pradesh	Haryana	Karnataka	Gujarat	Total	
					No.	%
Medical Officers	35	16	26	30	107	68.6
Other Health Supervisors of the area	4	—	9	—	13	13.3
Health worker	20	—	20	18	58	37.2
Village leader	6	—	3	—	9	5.8
Block Health Educator/B.E.E.	—	—	4	2	6	3.8
Teachers	—	—	2	—	2	1.3
We have fixed tour programme	—	3	—	5	8	5.1
Not consulted	—	—	9	10	19	12.2
Total Respondents	43	19	42	52	156	

Note: Multiple responses

*Table 6.6.*  
Considerations in planning visits by the Health Assistants

Consideration	Andhra Pradesh		Haryana		Karnataka		Gujarat		Total	
	C	F	C	F	C	F	C	F	C	F
Needs of the area	16	27	6	6	3	8	12	34	37 (23.9)	75 (48.4)
Possible returns of the visit	15	25	7	7	1	5	12	41	35 (22.6)	78 (50.3)
Efficiency of the worker	20	34	4	5	4	17	10	23	38 (24.5)	79 (51.0)
All workers to be supervised should be visited	19	33	1	3	1	7	11	23	32 (20.6)	66 (42.6)
To solve problems of workers	21	35	5	7	5	15	10	23	41 (26.5)	80 (51.6)
Routine visits	10	26	6	7	—	—	17	41	33 (21.3)	74 (47.7)
ATP prepared in consultation with MO	1	1	—	—	13	33	—	—	14 (9.0)	34 (21.9)
F.P., Immunization	—	—	—	—	—	—	19	6	19 (12.3)	6 (3.9)
Total respondents	43		18		42		52		155	

C — Clinic    F — Field

*Note:* (a) Figures in parenthesis are percentages

(b) Multiple responses

(c) One case of non-response excluded.



**Table 6.7**  
Determination of priority of field visits to the village by the Health Assistants

Priority	Male*	Female*	Total**
On the basis of master plan	24 (44.5)	21 (46.7)	71 (47.0)
Farthest & interior villages	4 (7.4)	3 (6.7)	23 (15.2)
Camps: Family Planning camps	16 (29.6)	12 (26.7)	41 (27.1)
Epidemic control camps	7 (13.0)	2 (4.4)	9 (6.0)
Orientation training camps	2 (3.7)	—	2 (1.3)
Team work in immunization	12 (22.2)	12 (26.7)	37 (24.5)
On request by villages	2 (3.7)	2 (4.4)	4 (2.6)
By reviewing the work done so far	4 (7.4)	2 (4.4)	6 (4.0)
Resistance for F.P. (area)	—	5 (11.1)	5 (3.3)
Malaria positive work	1 (1.8)	—	3 (2.0)
Others: More visits according to needs of the area	2 (3.7)	4 (8.9)	6 (4.0)
<b>Total Respondents</b>	<b>54</b>	<b>45</b>	<b>151</b>

*Note:* (1) \*Data not available by sex of the Health Assistants from Gujarat State  
 (2) \*\*Includes the Health Assistants of Gujarat State.  
 (3) Multiple responses  
 (4) Figures in parenthesis indicate percentages.  
 (5) Five Health Assistants (2 Male, 3 Female) did not respond to determination of priority of field visits to villages.

**Table 6.8**  
Number of days spent in a week by the Health Assistants at PHC, Sub-centre and Field

No. of days	P.H.C.		Sub-centre		Field/Village	
	Male	Female	Male	Female	Male	Female
0	3 (6.0)	—	1 (1.8)	—	—	—
1	32 (64.0)	24 (54.5)	12 (21.8)	2 (4.3)	1 (1.8)	6 (12.5)
2	9 (18.0)	15 (34.1)	9 (16.4)	16 (34.0)	6 (10.9)	7 (14.6)
3	2 (4.0)	4 (9.1)	13 (23.6)	14 (29.8)	5 (9.2)	6 (12.5)
4	—	—	10 (18.2)	13 (27.7)	14 (25.5)	14 (29.1)
5	1 (2.0)	—	7 (12.8)	2 (4.2)	24 (43.6)	12 (25.0)
6	2 (4.0)	1 (2.3)	3 (5.4)	—	4 (7.2)	3 (6.2)
7	1 (2.0)	—	—	—	1 (1.8)	—
<b>No. of respondents</b>	<b>50</b>	<b>44</b>	<b>55</b>	<b>47</b>	<b>55</b>	<b>48</b>

*Note:* 1. Data not available by sex for Gujarat State  
 2. Figures in parenthesis represent percentages.  
 3. Cases of non-response of six males, 4 females at PHC, one Male & Female at Sub-Centre and one male at field have been excluded.

Table 6.9  
Hours spent per day in the field

Hours spent	Andhra Pradesh						Haryana						Karnataka						Total					
	Sub-centre			Field/Village			Sub-centre			Field/Village			Sub-centre			Field/Village			Sub-centre			Field/Village		
	M	F		M	F		M	F		M	F		M	F		M	F		M	F		M	F	
<1	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	2 (2.2)	—	—	—	—	—	—	—	—
1-2	3	2	—	—	2	—	6	4	—	—	1	—	—	—	—	9 (20.0)	6 (12.5)	—	—	—	—	3 (6.2)	—	—
2-3	2	2	1	—	—	—	2	—	4	2	2	—	—	—	—	4 (9.0)	2 (4.2)	—	—	—	—	5 (8.9)	2 (4.2)	—
3-4	3	5	4	4	—	—	—	1	2	2	2	6	4	3	—	8 (17.8)	12 (25.0)	—	—	—	—	10 (17.9)	9 (18.7)	—
4-5	1	2	2	2	—	—	—	1	3	2	2	10	11	12	—	16 (13.3)	13 (27.1)	—	—	—	—	16 (28.6)	16 (33.3)	—
5-6	1	1	1	2	2	—	1	1	3	—	—	5	6	6	—	3 (6.8)	7 (14.6)	—	—	—	—	10 (17.9)	8 (16.0)	—
6+	2	—	4	2	2	—	1	—	—	—	—	—	—	—	—	3 (6.8)	—	—	—	—	—	4 (7.1)	2 (4.2)	—
No response	11	8	11	8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total respondents	12	12	12	12	12	12	12	7	12	7	7	12	21	21	21	45	40	40	45	40	45	40	45	40

Note: (1) Figures in parenthesis are percentages.

(2) Cases of non-response of hours per day in the field by 11 Male and 8 Females at both Sub-centre and at Field/Village levels in Andhra Pradesh have been excluded.



Table 6.10

Possibilities of full coverage and full course of immunization of children as seen by Health Assistants

Possibility	Andhra Pradesh		Haryana		Karnataka		Gujarat		Total	
	Full Cove- rage	Full Cour- se	Full Cove- ge	Full Course	Full Cove- rage	Full Course	Full Cove- rage	Full Course	Full Cove- rage	Full Course
Possible	5	8	15	15	3	5	14	6	37 (27.00)	34 (24.8)
Not possible	19	16	4	4	39	37	38	46	100 (73.0)	103 (75.2)
Total Respondents	24		19		42		52		137	

Note: 1. Figures in parenthesis are percentages

2. 19 Health Assistants from AP did not respond

Table 6.11

Organisation of nutrition and family planning education activities at sub-centre level by the Health Assistants

Methods of Organising education activities	Andhra Pradesh	Haryana	Karnataka	Gujarat	Total	%
Education of mothers	12	1	16	27	56	35.9
Group meetings/through leaders/teachers	20	8	12	27	67	42.9
Demonstration of cheaper nutritious food preparation	4	1	5	28	38	24.4
Regular distribution of iron & folic acid tablets.	4	—	—	25	29	18.6
Distribution of pamphlets/exhibits/posters	8	1	5	16	30	19.2
House to house visit/ Individual approach	17	5	—	—	22	14.1
Films/shows/camps/ conducting education sessions	5	13	12	23	53	34.0
Total Respondents	43	19	42	52	156	

Note: 1. Multiple responses

**Table 6.12**  
Referral of cases by Health Assistants to different Health Institutions

Type of cases	PHC	HQ Hospital	TB Centre	Leprosy Centre
G.E. Cases	51 (49.0)	12 (11.5)	—	—
TB Cases	17 (16.4)	10 (9.6)	11 (10.6)	—
Sterilization and MTP	7 (6.7)	5 (4.8)	—	—
FP adopters with complications	5 (4.8)	3 (2.9)	—	—
Difficult labour case	11 (10.6)	16 (15.4)	—	—
Abnormal Pregnancy	7 (6.7)	6 (5.8)	—	—
Leprosy	13 (12.5)	5 (4.8)	—	4 (3.4)
Fever/Rash	15 (14.4)	1 (0.9)	—	—
Injuries/odema accidental poisoning	15 (14.4)	3 (2.9)	—	—
Encephalatis	2 (1.9)	6 (5.8)	—	—
Measles	6 (5.8)	—	—	—
Skin diseases	5 (4.8)	—	—	1 (0.9)
Snake bite	4 (3.8)	1 (0.9)	—	—
Communicable diseases	3 (2.9)	—	—	—
Chickenpox	3 (2.9)	—	—	—
Severe anaemia	3 (2.9)	—	—	—
Vomitting case	1 (0.9)	1 (0.9)	—	—
Tetanus	2 (1.9)	—	—	—
Jaundice	1 (0.9)	1 (0.9)	—	—
VD Cases	1 (0.9)	—	—	—
Epilepsy	1 (0.9)	—	—	—
Polio	1 (0.9)	—	—	—

*Note:* 1. The data of Gujarat State not available, hence data relate to 104 respondents from the other three states  
2. Figures in parenthesis are percentages  
3. Multiple responses

**Table 6.13**  
Health Assistants knowledge of school health programme by their sex

Knowledge of Programme	Andhra Pradesh		Haryana		Karnataka		Gujarat	Total	%
	M	F	M	F	M	F	M & F	M & F	M & F
Regular School visits	4	3	—	—	2	1	16	26	16.7
Immunisation/T.T.	11	11	2	5	19	20	17	85	54.5
Medical Check-up	16	16	11	6	20	19	27	115	73.7
Health education	13	9	—	—	12	17	23	74	48.0
Environmental Sanitation	9	5	1	1	—	—	5	21	13.5
Nutrition education	13	11	4	—	—	—	6	34	21.8
Training of teachers	1	2	1	—	—	—	7	11	7.0
Personal Hygiene	5	2	—	—	—	—	—	7	4.5
Total Respondents	23	20	12	7	21	21	52	156	

*Note:* 1. Multiple responses  
2. M—Male F—Female



**Table 6.14**  
Type of planning and implementation activities performed for School Health Programme

Type of planning and implementation activities performed for

Types of planning	Andhra Pradesh		Haryana		Karnataka		Gujarat		Total							
	M		F		M		F		M & F		Male*		Female*		Both**	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Medical check-up	19	17	8	6	17	18	32	44	78.6	41	85.4	117	75.0			
Health education	23	20	10	7	20	16	45	53	94.6	43	89.6	141	90.4			
Immunization	23	20	11	7	21	19	45	55	98.2	46	95.8	146	93.6			
Referral	21	19	7	7	—	—	29	28	50.0	26	54.2	83	53.2			
Nutrition	23	19	5	5	—	—	28	28	50.0	24	50.0	80	51.3			
Environmental sanitation	23	20	10	7	—	—	37	33	36.9	27	56.2	87	55.8			
Training of teachers	15	13	4	5	—	—	19	19	33.9	18	37.5	56	35.9			
Personal hygiene	1	1	—	—	—	—	—	1	1.8	1	2.1	2	1.3			
Total respondents	23	20	12	7	21	21	52	56	48	156						

Note: \*Excludes Gujarat State as service data are not available

\*\*Includes Gujarat State.

Multiple responses

*Table 6.15*  
Objectives of the supervision of the Health Workers as stated by Health Assistants

Objectives	Andhra Pradesh		Haryana		Karnataka		Gujarat		Total	
	M	F	M	F	M	F	M	F	M	F
To help the workers in planning his/her activities	22	20	19	6	3	5	26	16	70 (79.5)	47 (69.1)
To provide inservice training	13	14	1	1	5	5	5	5	20 (22.7)	25 (36.8)
To see whether he/she is working alright	22	17	9	4	11	13	31	20	73 (82.9)	54 (79.4)
To insert IUD/help in immunization programme	—	12	—	4	—	14	1	3	1 (1.1)	33 (48.5)
To check records and help in preparing returns	20	17	7	6	20	23	17	11	64 (72.7)	57 (83.8)
To help the workers in replenishment of stock	16	18	3	5	6	11	9	3	34 (38.6)	37 (54.4)
To asses the quantity and quality of worker's work	19	19	9	3	9	8	26	11	63 (71.6)	41 (60.3)
Others (Health Education)	—	—	—	—	—	—	2	—	2 (2.3)	—
Total Respondents	23	20	12	7	21	21	32	20	88	68

Note: 1. Multiple responses

2. Figures in parenthesis indicate percentages.



Table 6.16

Aspects of work of the Health Workers supervised by the Health Assistants in the clinic and field.

Aspects	Andhra Pradesh		Haryana		Karnataka		Gujarat		Total	
	IC	IF	IC	IF	IC	IF	IC	IF	IC	IF
Medicines	12	24	16	10	18	8	19	47	65 (41.7)	89 (57.0)
Equipment	12	24	15	8	14	5	17	40	58 (37.2)	77 (49.4)
Ante-natal examination	4	3	—	—	—	—	—	—	4 (2.6)	3 (1.9)
Diary	12	25	15	14	39	13	7	31	73 (46.8)	83 (53.2)
Immunization	3	9	2	4	—	—	3	7	8 (5.1)	20 (12.8)
Midwifery Kit	9	7	6	4	7	6	10	25	32 (20.5)	42 (26.9)
Verification of all health activities	7	12	1	5	12	—	—	—	20 (12.8)	17 (10.9)
Record keeping	19	18	16	6	39	13	17	40	91 (58.3)	77 (49.4)
No clinic	—	—	—	—	8	—	—	—	8 (5.1)	—
Follow-up	—	—	—	—	—	—	3	2	3 (1.9)	2 (1.3)
Total Respondents	43		19		42		52		156	

IC — In the Clinic

IF — In the field

1. Figures in parenthesis are percentages.

2. Multiple responses

*Table 6.17*  
Methods of assessing the performance of the worker adopted by Health Assistants

Methods	Andhra Pradesh		Haryana		Karnataka		Gujarat	Total	
	M	F	M	F	M	F	M & F	No.	%
Field verification for regular visits.	11	11	5	5	6	7	18	63	40.6
Scrutiny of records	15	15	9	3	7	12	28	89	57.4
Enquiring the people	12	9	3	—	1	3	6	34	21.9
Achievement of the targets	9	4	2	3	15	17	16	66	42.6
Popularity with the people	2	—	1	—	7	8	4	22	14.2
Area coverage	—	—	—	—	1	2	—	3	1.9
Total Respondents	23	19	12	7	21	21	52	155	

*Note:* M — Male Health Assistants  
F — Female Health Assistants  
1. Multiple responses  
2. No response by one Health Assistant.

*Table 6.18*  
Specific instructions to workers about their daily plan of work (regarding identifying priority health programme) by Health Assistants

Instructions	Andhra Pradesh	Haryana	Karnataka	Gujarat	Total
Family Planning	23	4	29	8	64 (45.4)
Malaria	5	2	18	5	30 (21.3)
Immunization	20	3	9	11	43 (30.5)
Health Education	4	—	3	21	28 (19.9)
Follow-up of sterilization cases	7	—	—	6	13 (9.2)
Environmental sanitation	3	2	—	4	9 (6.4)
Detection of epidemic cases/ communicable disease cases	15	2	16	4	37 (26.2)
Where achievements are less	7	—	—	—	7 (5.0)
Low socio-economic status	3	—	—	—	3 (2.1)
Treatment of minor ailments.	9	—	—	—	9 (6.4)
According to requirements of the people.	—	3	—	—	3 (2.1)
MCH activities	—	—	14	—	14 (9.9)
Total Respondents	41	11	35	52	141

*Note:* 1. Multiple responses  
2. 17 Health Assistants did not respond to specific instructions provided by them.  
3. Figures in parenthesis indicate the percentages.



**Table 6.19**  
Methods adopted by Health Assistants in involving community in health service activities

Methods	Andhra Pradesh	Haryana	Karnataka	Gujarat	Total
Conducting clinic	4	—	—	4	8 (5.2)
Health Education	6	1	—	25	32 (20.9)
Participation in community/youth clubs, village <i>panchayat</i> meetings.	21	11	12	33	77 (50.3)
Take the help of HGs and Trained <i>Dais</i> .	7	—	—	2	9 (5.9)
Work through satisfied customers.	3	—	4	16	23 (15.0)
By conducting FP orientation camp.	6	3	19	—	28 (18.3)
Cultural programme	2	—	—	—	2 (1.3)
By making them members of Health Advisory Committee	4	—	—	—	4 (2.6)
Group meeting	—	—	14	—	14 (9.2)
Close contact with leaders	—	—	3	—	3 (1.9)
Do not involve community	3	2	—	—	5 (3.3)
No response	1	2	—	—	3 (1.9)
Total Respondents	42	17	42	52	153

- Note:** 1. Multiple responses  
2. Three Health Assistants, one from Andhra and two from Haryana, did not respond to the methods adopted in involving the community in Health Service Activities.  
3. Figures in parenthesis are percentages.

*Table 6.20*  
Number of registers maintained and returns submitted by Health Assistants

No. of Registers	Health Assistants		Total
	Male	Female	
1	4 (4.6)	7 (10.3)	11 (7.1)
2	7 (8.0)	1 (1.5)	8 (5.1)
3	6 (6.8)	3 (4.4)	9 (5.8)
4	7 (8.0)	5 (7.4)	12 (7.7)
5	13 (14.8)	13 (19.1)	26 (16.7)
6	8 (9.1)	5 (7.4)	13 (8.3)
7-8	13 (14.8)	13 (19.1)	26 (16.7)
8-10	7 (8.0)	6 (8.8)	13 (8.3)
More than 10	23 (26.1)	15 (22.1)	38 (24.4)
Total	88	68	156

No. of returns	Health Assistants		Total
	Male	Female	
1	14 (16.4)	17 (25.4)	31 (20.4)
2	8 (9.4)	6 (8.9)	14 (9.2)
3	6 (7.0)	5 (7.4)	11 (7.2)
4	10 (11.8)	9 (13.4)	19 (12.5)
5-6	15 (17.6)	14 (20.9)	29 (19.1)
7-8	4 (4.7)	8 (11.9)	12 (7.9)
9-10	12 (14.1)	2 (3.0)	14 (9.2)
11-12	6 (7.0)	2 (3.0)	8 (5.3)
13-14	5 (5.9)	2 (3.0)	7 (4.6)
15 +	5 (5.9)	2 (3.0)	7 (4.6)
Total	85	67	157

*Note:* 1) Figures in parenthesis are percentages.

2) Four Health Assistants did not specify the number of returns submitted by them.



## Management Training Needs of Health Workers

### JOB ANALYSIS

After studying the job description of the multipurpose health workers (male and female), the areas that were felt to be requiring management training are listed below:

#### *Male Worker*

- Planning and scheduling of daily, weekly and monthly activities.
- Surveillance and referral of cases
- Record keeping
- Inventory and stock management
- Monitoring and feedback with reference to HGs and *dais*
- Interpersonal communication
- Motivation techniques
- Participating skill in meetings—staff meetings and village community meetings.

#### *Female Worker*

In addition to the above she requires training for management of sub-centres.

### FINDINGS OF THE SURVEY

A total number of 196 health workers were interviewed in the states of Andhra Pradesh (53), Haryana (42), Karnataka (48) and Gujarat (53), with male and female workers of almost equal number.

#### *Background information*

Majority of the health workers interviewed belonged to the age group 30-40 years (Table 7.1). Most of the workers (87.2 per cent) were married though the percentage of male workers' was higher (97.7 per cent) compared to the female (79.4 per cent). As far as religion is concerned, a large majority of them were Hindus, the rest being Christian and Muslims.

Generally, most of the health workers (65.8 per cent) have had education ranging from middle to higher secondary level. On an average, the educational levels of male

health workers was higher than those of the female health workers (Table 7.2).

### *Professional training and experience*

About 25 per cent of the workers had their professional training within the last five years and about 50 per cent of them within the last few years. Thus, most of them have had a long period of service experience behind them. About 63 per cent of the workers reported having undergone a reorientation training in the MPW scheme. In the case of female workers the difference between job function as ANMs and their job requirements as female multipurpose workers was not much. However, there was insignificant difference between what the male workers had received by way of training under the uni-purpose system (*e.g.* as sanitation inspector, as leprosy workers, as malaria surveillance worker, as vaccinator and so on) and their job duties as multi-purpose male workers. (Table 7.3 and 7.4). Despite their experience in the health service, the majority of the male workers found themselves at a disadvantage in their present position. The orientation training in the multipurpose scheme has covered only 63 per cent of the workers (Table 7.5). However, only half of the workers had found the orientation training useful in a moderate sense.

Asked about the adequacy of training and what they got out of it, only 35.2 per cent replied that they understood their functions and 22.3 per cent said that they were clear about the methodology of work and same per cent understood immunization schedule but the impact of the training had been much less than expected. (Table 7.6). At the same time, when asked to suggest for further training, the responses had been poor.

### *Work area*

The number of villages covered by a health worker varied from region to region, depending on the geographic location and population density of the villages. On an average, the workers covered 2—5 villages each in the intensive areas and 6—9 villages in the twilight areas. About half of the workers covered a population of 5,000 or less each in the intensive area and nearly an equal population in the twilight area. The rest of the workers covered a still higher population each even in their intensive area.

A few of the workers could not distinguish between their intensive and twilight areas. The number of eligible couples to be covered by a worker for purposes of family planning varies from 4000 to 6000 for the majority of the workers in the intensive area, and was more than 6000 in twilight area. Nearly 90 per cent of the workers reported they could cover their intensive area in a month's time, some even in two weeks' time. However, effective coverage of the population required a month or a little more in the case of most of the workers.

Almost all the workers had their villages at distances of around 5 kms from their respective sub-centres. About three-fourths of the workers lived in the sub-centre village and the rest in the nearby villages under the sub-centre. Thus, there does not seem to be much of a locational problem of the sub-centre in the areas under study.



### *Planning and scheduling of work*

The major activities of the female workers were reported to comprise of ante-natal, natal, post-natal activities, child care services and treatment of minor ailments. The other activities included family planning, training of *dais* and so on. In case of male workers the major activities were reported as health, nutrition and sanitation education, immunization, family planning work, treatment of minor ailments, vital statistics etc. (Table 7.7).

Most of the workers said that they took into consideration the requirements of the above services in specific localities while planning their field visits. (Table 7.8). But nearly 50 per cent of the workers also agreed that their field visits were planned in accordance with the instructions from the PHC and in line with fixed tour schedules. It is difficult to estimate the extent to which they were able to make deviations from the norms and pattern set out for all workers. In Gujarat, two-thirds of the workers reported that their tour programmes were communicated to the public through the HGs. However, general opinion of the workers was that public awareness about fixed programmes of such visits was very poor. Most of the workers could not suggest any means of improving public awareness of their visits. A few, however suggested that shop-keepers, village leaders, teachers and HGs could be the channels of communicating such information. However, there seemed to be enough public awareness of the workers' visits at the time of general vaccination against communicable diseases and at the time of family planning camps.

Almost all the workers carried with them their registers and a few medicines for minor ailments to the field. Most of the male workers also carried their kits provided to them. As far as female workers were concerned, the responses varied. In Gujarat most of them carried their kits to the field; in Haryana the kit was considered unnecessary and heavy to be carried to the field everytime. On the other hand most of the workers emphasised that health and family planning education was one of their most important activities, but none carried with them the educational aids like the manuals, pamphlets, flash cards etc. to the field.

For providing services in the field about 50 per cent of the workers followed the system of visiting every house while other workers adopted the system of sitting in a central place, in addition to making house-to-house visits.

### *Supervision and guidance from above*

The health workers were supervised in their work by male and female health supervisors respectively and also by the medical officers of their respective PHCs. The health supervisors visited the clinic and fields two to three times a month. However, 47 per cent of the supervisors did not seem to visit the clinic even once (Table 7.9).

The major responses of the workers regarding activities of the supervisors in the field were checking up the activities of the workers, providing guidance and helping in routine work etc. The general opinion was that the supervisors were not of much use in family planning motivation, in the insertion of IUD and in the supply of stocks and organising field meetings. (Table 7.10).



About one-eighth of the workers reported that the medical officers were not regularly visiting the clinics and the field. The main help rendered by the medical officers included check regular work, advising for family planning and treatment of patients (7.11).

Most of the workers wanted more frequent field visits by the supervisors and more technical guidance.

The main problems faced by the female health workers in conducting sub-centre clinic were the lack of sitting accommodation for the patients, non-availability of medicines, equipment and stationery, inadequate supply of contraceptives, and the non-availability of educational aids.

Mostly complicated delivery cases, cases of high fever, leprosy, T.B., accidents, were being referred to the PHC and the government hospitals (Table 7.12).

Regarding immunization of children, nearly 45 per cent of the workers reported that they would not be able to ensure full coverage and full course of immunization. About 33 per cent of the female workers mentioned that proper record keeping would help in ensuring full course of immunization and coverage (Table 7.13 and 7.14).

The health workers were supposed to ensure adequate availability of the contraceptives in the field. About half of the workers reported that they did this mostly by personal distribution; the rest did it by checking the registers of the depot-holders and through occasional enquiries among contraceptive users (Table 7.15 and 7.16).

In the areas of health education, there seemed to be an over-emphasis on family planning motivation and to a certain extent on about malaria education. Topics relating to sanitation, hygiene, need for immunization and nutrition hardly formed part of the educational activities of the workers. In fact, the workers did not even have the necessary educational materials and aids for this purpose.

About 90 per cent of the workers reported resistance from the community in various forms in pursuing family planning motivation activities, and few faced difficulties in the immunization programme. Most of them expressed the opinion that community resistance could be significantly reduced by involving the local leaders and teachers, by utilising satisfied acceptors, by frequent contacts with resistant people, and through various educational approaches for group and individual education (Table 7.17).

### *Staff meeting*

The health workers are required to assemble in the PHC once in every month. In these meetings, the participation of the workers was rather limited. Sometime they bring in some problems of the field and provided some other information to the PHC medical officers regarding specific follow-up cases, communicable diseases etc. But, for the most part, they receive instructions and targets from the medical officers for the implementation of the various programmes, and more importantly that of the family planning programme. By and large, communication in these meetings was a one way process.



## *Logistics*

As far as Vitamin 'A' solution' iron and folic acid tablets, vaccines and contraceptives were concerned, more than 70 per cent of the workers reported of having received adequate supply from the PHC. In a few cases, however, (*e.g.* in Karnataka) as many as 75 per cent female workers received inadequate supply of Vitamin 'A' solution. On the other hand, about 58 per cent of the workers complained of inadequate supply of medicines (Table 7.18).

While 42 per cent of the workers did not ensure regular supply of drugs, about 52 per cent of them tried to do so by collecting their supplies either directly from the PHCs and sometime by borrowing from fellow workers. (Table 7.19).

## *Record keeping*

Most of the field workers maintained daily diary of their activities, from which these informations were entered into various registers and then the registers were utilized to prepare reports to be sent to the PHC. The diary carried entries like field visits (area visited, date etc.), family planning activities and so on. Those who did not maintain a diary, entered their activities straight into the registers they carried with them.

On an average, a worker had to maintain 10 to 15 registers pertaining to the different activities, and had to send about five reports to the PHC per month. This took away about 1.5 to 2 hours of their daily time. Most of the workers complained that registers were not supplied to them, that there were too many registers to be maintained, which took away a lot of their money and time. The MPW scheme envisaged standardization of registers and record keeping for the workers, but this had not been implemented in any of the regions under study.

## *Inter and intra-department coordination*

More than 60 per cent of the health workers did not have any coordination of activities with personnel of other departments. The only form of coordination that was found to have existed was in the workers' occasional participation in the local *panchayat* committee meetings where the subject matter of discussion mostly centred around either on family planning and/or sanitation.

As far as the HGs and trained *dais* were concerned, more than 50 per cent of the workers sought and received help from them for motivating family planning cases and 48 per cent immunization activities and in malaria work. Besides these, the workers did not feel they required any further help from the *dais* and HGs. The general feeling was that involvement of the HGs and *dais* in the government programmes could be improved significantly by giving various incentives.

## *Community participation*

Community level participation by the workers appeared to be very poor. More than 75 per cent of the workers never attended the village and *panchayat* committee meetings. A worker was rarely found attending the meetings organised by youth

clubs, *mahila mandals* and other voluntary agencies in the village. Thus, other than personal contacts, there did not seem to be any systematic methods for promoting community participation by the workers. Most often the workers worked in isolation from one another without team-work and thus made the problem of participation more difficult. The other reasons for inadequate community participation were lack of emphasis and support by the PHC medical officers and lack of time on the part of the workers for such activities. Moreover, sometimes frequent transfers of the workers made it difficult to establish good rapport with the community in a short time.

## MANAGEMENT TRAINING NEEDS

### *Implications of survey findings*

After conducting the interviews and observations of the health workers (male and female), several areas that were indentified for management training are listed below:

- Planning and scheduling of field work and activities
- Developing and using client information—surveillance to identify and screen target population, risk cases etc.
- Referral of patients
- Motivating people
- Liaison with supervisors of PHCs
- Stock management
- Cooperation and team work.
- Public relationship with volunteers, leaders and group in the community.
- Monitoring and helping HGs/ *dais*

For female workers, supervision of *dais* was in addition an essential area which needed to be strengthened by training.



*Table 7.1*  
Age and sex distribution of the Health Workers

Age (Years)	Andhra Pradesh			Gujarat			Haryana			Total			
	M	F	T	M	F	T	M	F	T	M	F	T	%
20-25	—	—	—	3	1	4	—	2	2	3	3	6	(4.0)
25-30	1	5	6	4	8	12	4	7	11	9	20	29	(19.6)
30-35	7	9	16	11	13	24	10	7	17	28	29	57	(38.5)
35-40	12	7	19	4	1	5	4	3	7	20	11	31	(21.0)
40-45	6	4	10	2	2	4	2	1	3	10	7	17	(11.5)
45-49	—	—	—	—	2	2	—	1	1	—	3	3	(2.1)
50 and above	—	2	2	—	2	2	—	1	1	—	5	5	(3.4)
Total	26	27	53	24	29	53	20	22	42	70	78	148	100.0

*Note:* (1) Data for Karnataka State are not available.

(2) M — Male F — Female T — Total

Table 7.2  
Educational status of the Health Workers

Educational Status	Andhra Pradesh			Gujarat			Haryana			Karnataka			Total		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Upto Primary	—	—	—	—	6	6	—	—	—	—	1	1	—	7	7
Primary to Middle	—	2	2	11	19	30	—	1	1	—	4	4	11	26	37
Middle to Higher Secondary	26	22	48	6	4	10	18	20	38	15	18	33	65	64	129
Higher Secondary to College	—	3	3	6	—	6	1	1	2	9	1	10	16	5	21
Above College Degree	—	—	—	1	—	1	1	—	1	—	—	—	2	—	2
Total	26	27	53	24	29	53	20	22	42	24	24	48	94	102	196

Note: (1) M — Male F — Female T — Total

(2) Figures in parenthesis indicate the percentages



**Table 7.3**  
**Professional training of the Health Worker (Male)**

Professional Training	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Sanitary Inspector	13	6	—	—	19 (21.1)
Leprosy Paramedical Course	1	3	—	—	4 (4.4)
Health Worker Under					
— MPWs training	—	15	15	15	45 (50.0)
— BHW training	2	—	—	—	2 (2.2)
— Malaria	2	3	2	4	11 (12.2)
— Vaccination	—	4	—	—	4 (4.4)
— Others	3	8	2	—	13 (14.4)
No professional training	1	2	1	6	10 (11.1)
<b>Total respondents</b>	<b>22</b>	<b>24</b>	<b>20</b>	<b>24</b>	<b>90</b>

*Note:* (1) Multiple responses.

(2) Four Health workers from Andhra Pradesh did not respond as regards to the professional training by them.

(3) Figures in parenthesis indicate the percentages.

**Table 7.4**  
**Professional Training of Health Workers (Female)**

Training	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
ANM Course	13	29	12	—	54
Female Health Worker (course under MPWs)	—	13	8	24	45
Mid-wifery training	5	—	—	—	5
Trained dais	—	1	1	—	2
First-aid training	—	1	1	—	2
Family Planning re-orientation	—	2	—	—	2
<b>Total response</b>	<b>27</b>	<b>29</b>	<b>22</b>	<b>24</b>	<b>102</b>

*Note:* Multiple responses.

Table 7.5  
Type of inservice training attended by Health Workers

Inservice training	Andhra Pradesh			Gujarat			Haryana			Karnataka			Total		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Family Planning	—	1	1	—	—	—	—	1	1	—	3	3	—	5	5
MPW	14	15	29	3	14	17	13	19	32	16	17	33	46	65	111
Leprosy	—	—	—	—	3	3	—	—	—	2	—	2	2	3	5
Tuberculosis	—	—	—	—	2	2	—	1	1	—	—	—	—	3	3
Malaria Microscopic	—	—	—	—	—	—	2	—	2	5	—	5	7	—	7
EPI	1	—	1	2	—	2	—	—	—	—	—	—	3	—	3
BCG	—	—	—	18	10	28	—	—	—	—	—	—	18	10	28
No Inservice Training	1	1	2	1	—	1	5	1	6	1	4	5	8	6	14
Total respondents	16	17	33	24	29	53	20	22	42	24	24	48	84	92	176

Note: 1. M — Male Health Workers F — Female Health Workers T — Total Health Workers

2. Multiple responses

3. In A.P. 10 male and 10 female health workers did not identify any inservice training attended by them.



**Table 7.6**  
Usefulness of the last inservice training for better delivery of the health services as seen by Health Workers

Usefulness of inservice training	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Understand job functions	14	25	17	12	68 (35.2)
Clear about methodology of work	15	20	6	2	42 (22.3)
Can maintain records and registers in a better way	—	—	—	1	1 (0.5)
Knows techniques of blood taking	2	6	5	8	21 (10.9)
Knows about FW Programmes	17	9	1	7	34 (17.6)
Knows about TB & Leprosy	2	4	2	5	13 (6.7)
Understood Immunization Schedule	8	28	1	6	43 (22.3)
Health Education Techniques	8	5	4	2	19 (9.8)
Chlorination of wells	7	1	—	—	8 (4.1)
Minor ailments	5	—	—	2	7 (3.6)
Not undergone inservice training	5	—	6	1	12 (6.2)
Total respondents	53	52	42	46	193

*Note:* (1) Multiple responses.

(2) Three respondents one from Gujarat and two from Karnataka did not respond to the usefulness of last inservice training.

(3) Figures in parenthesis indicate the percentages.

Table 7.7  
Main job functions/activities of Health Workers as MPHWs

Job Functions/ Activities	Andhra Pradesh		Haryana		Karnataka		Total	
	Without Probe	With Probe	Without Probe	With Probe	Without Probe	With Probe	Without Probe	With Probe
Antenatal services	40	1	25	6	24	7	89 (62.2)	14 (9.8)
Natal services	21	4	24	5	15	9	60 (42.0)	18 (12.6)
Post-natal services	30	1	24	6	20	11	74 (51.8)	18 (12.6)
Child care services	37	5	22	12	16	12	75 (52.5)	29 (20.3)
Treatment of minor ailments	42	9	15	16	8	9	65 (45.5)	34 (23.8)
Health & personal hygiene education	42	4	25	20	5	13	72 (50.4)	37 (25.9)
Immunization	43	4	33	10	27	4	103 (70.1)	18 (12.6)
Nutrition education	44	10	32	14	7	8	83 (58.0)	32 (22.6)
F.P. education	46	6	32	14	43	5	121 (84.6)	25 (17.5)
Distribution of contraceptives	37	7	17	20	19	18	73 (51.1)	45 (31.5)
Vital statistics	35	6	10	12	26	17	79 (52.2)	35 (24.5)
Training of <i>dais</i>	3	—	13	14	—	—	11 (7.7)	14 (9.8)
Supervisory guidance to various HGs	16	2	9	20	—	4	25 (17.5)	26 (18.2)
Others	—	5	24	6	26	7	50 (35.0)	18 (12.6)
Total respondents	53		42		48		143	

Note: (1) Data for Gujarat State are not available.

(2) Multiple responses.

(3) Figures in parenthesis indicate the percentages.



*Table 7.8*  
Major consideration in planning field visit by Health Workers

Consideration	Andhra Pradesh			Gujarat			Haryana			Karnataka			Total
	Without Probe	With Probe	Total	Without Probe	With Probe	Total	Without Probe	With Probe	Total	Without Probe	With Probe	Total	Without probe
Ante-natal care for pregnant mothers	39	1	40	35	2	37	21	7	28	17	4	21	112
Complicated natal care	14	4	18	20	7	27	15	7	22	20	3	23	69
Post-natal care to mothers	27	6	33	25	7	32	16	7	23	14	—	14	82
Child care	34	5	39	23	21	44	18	6	24	11	5	16	86
Complete course of vaccination	23	5	28	26	22	48	21	11	32	9	10	19	79
F.P. education to priority ECS	52	3	55	44	9	53	31	11	42	14	18	32	141
Follow-up of sterilization & IUD cases	31	5	36	—	—	—	10	19	29	16	10	26	57
Regular supply of nirodh and oral contraceptives	31	4	35	32	18	50	17	14	31	13	11	24	93
Notification of communicable diseases	37	8	45	22	2	24	15	20	35	10	13	23	84
Education on personal hygiene & environmental sanitation	44	4	48	26	24	50	23	12	35	9	14	23	102
Malaria & referral cases	1	1	2	7	36	43	15	—	15	—	10	10	23
Immunization & others	—	1	1	47	6	53	7	—	7	15	14	29	69
Total respondents			53			53			42			48	196

*Note:* Multiple responses.

**Table 7.9**  
Number of visits made during a month by Health supervisors as reported by Health Workers

	Andhra Pradesh	Haryana	Karnataka*	Total**	%
<i>In Clinic</i>					
No visit	26	19	11	56	47.1
One visit	3	7	6	16	13.4
Two visits	8	2	2	12	10.1
Three visits	16	14	5	35	29.4
Total	53	42	24	119	
<i>In Field</i>					
No visit	3	4	3	10	7.0
One visit	6	2	9	17	11.9
Two visits	5	8	14	27	18.9
Three visits	4	3	9	16	11.2
Four visits	28	7	10	45	31.5
Five and more visits	7	18	3	28	19.6
Total	53	42	48	143	

*Note:* (1) \*Relates only to female Health Workers  
(2) \*\*Includes data for Gujarat State.



*Table 7.10*  
Activities rendered by the Supervisors in the Clinic/Field as stated by Health Workers

Activities	Andhra Pradesh			Gujarat			Haryana			Karnataka			Total		
	In Clinic	In Field	—	In Clinic	In Field	—	In Clinic	In Field	—	In Clinic	In Field	—	In Clinic	In Field	—
Not visited	—	—	—	—	3	—	—	—	—	—	3	—	— (0.0)	6 (3.1)	—
Helping in regular work	24	38	—	23	38	—	23	27	—	9	27	—	79 (43.6)	130 (68.1)	—
Checking referred patients	24	43	—	21	32	—	20	15	—	4	18	—	69 (38.1)	108 (56.5)	—
Inserting IUD	10	7	—	6	9	—	2	5	—	9	8	—	29 (16.0)	29 (15.2)	—
Giving follow-up services	22	45	—	15	14	—	9	19	—	4	16	—	50 (27.6)	94 (49.2)	—
Checking the work	25	42	—	21	37	—	15	21	—	5	41	—	66 (36.4)	141 (73.8)	—
Speaking in the meetings of promotional work	14	30	—	4	9	—	4	13	—	—	18	—	22 (12.1)	70 (36.6)	—
Providing guidance	20	32	—	25	36	—	13	14	—	2	31	—	60 (33.2)	113 (59.2)	—
Motivation of F.P.	—	1	—	2	3	—	2	4	—	—	2	—	4 (2.2)	10 (5.2)	—
Supply of regular stock	—	—	—	—	2	—	—	—	—	—	7	—	—	9 (4.7)	—
Organise group meetings	—	1	—	1	2	—	—	—	—	—	—	—	1 (0.5)	9 (4.7)	—
Organise spraying	—	2	—	—	—	—	5	3	—	—	28	—	5 (2.8)	33 (17.3)	—
Checking the records	—	—	—	—	—	—	9	7	—	—	—	—	9 (4.9)	7 (3.7)	—
Total respondents	52	52	—	39	49	—	42	42	—	48	48	—	181	191	—

Note: (1) Multiple responses.

(2) Figures in parenthesis indicate the percentages.

(3) 15 cases from In clinic and 5 cases from In field were excluded due to non-response.

*Table 7.11*  
Guidance/help provided by the MO in the Clinic/Field to the Health Workers

Activities	Andhra Pradesh		Gujarat		Haryana		Karnataka		Total	
	In Clinic	In Field	In Clinic	In Field	In Clinic	In Field	In Clinic	In Field	In Clinic	In Field
Not visiting	4	—	—	—	11	5	6	17	21 (12.7)	22 (11.4)
Not provided	8	10	—	—	—	—	—	—	8 (4.8)	10 (5.2)
Treating the patients	10	12	21	32	11	6	7	7	49 (30)	57 (29.7)
Advising for F.P.	2	1	2	3	7	11	7	21	8 (4.8)	36 (18.8)
Inserting IUD	2	8	6	9	—	2	—	6	8 (4.8)	25 (13.0)
Check regular work	3	17	21	37	—	—	3	3	27 (16.2)	57 (29.7)
Environmental sanitation	—	3	—	—	4	4	—	—	4 (2.4)	7 (3.7)
Advice to improve the quality of work	2	12	—	—	—	—	—	12	2 (1.2)	24 (12.5)
Helps to contact community leaders	2	4	2	3	1	3	—	2	5 (3.0)	12 (6.3)
Enquire about position of duty	2	4	—	2	—	—	—	—	2 (1.2)	6 (3.2)
Helping in regular work	—	—	23	38	12	14	—	—	35 (21.1)	52 (27.1)
Total Respondents	37	53	39	49	42	42	48	48	166	192

Note: (1) Multiple responses.

(2) Figures in parenthesis indicate the percentages.

(3) 30 cases from 'In Clinic' and 4 cases from 'In field' did not respond; so excluded from the total.



**Table 7.12**  
Type of cases referred by Health Workers

Type of Cases	Andhra Pradesh	Gujarat	Haryana	Total	%
Severe Anaemic	—	16	8	24	16.2
Complicated ANC's	24	30	23	77	52.0
Complicated PNC's	7	—	4	11	7.4
Fever with rash	1	—	3	4	2.7
High fever cases	9	18	12	39	26.4
Complicated FP adopters	11	12	7	30	20.3
GE cases	39	1	15	55	32.2
Poisoning	1	—	—	1	0.7
Accident	19	25	20	64	43.2
Suspected cases of TB/Leprosy	23	58	9	90	60.8
Chronic diseases	4	20	1	25	16.9
Epidemic cases	8	25	—	33	22.3
Others	17	20	5	42	28.4
<b>Total</b>	<b>53</b>	<b>53</b>	<b>42</b>	<b>148</b>	

*Note:* (1) Multiple responses.

(2) Data not available for Karnataka State.

**Table 7.13**  
Ways adopted for full coverage of children for immunisation by Health Workers

Ways of ensuring full coverage of children	Andhra Pradesh	Gujarat	Haryana	Total	%
Not ensuring	25	34	7	66	44.6
Unit-wise coverage	1	11	—	12	8.1
Maintain cards of immunisation	20	3	33	56	37.8
Oral enquiry	7	6	—	13	8.8
Camp	—	—	2	2	1.4
School visit	—	1	—	1	0.7
Availability of vaccine	5	1	7	13	8.8
<b>Total</b>	<b>53</b>	<b>53</b>	<b>42</b>	<b>148</b>	

*Note:* (1) Multiple responses

(2) The data for Karnataka State was not available

*Table 7.14*  
Ways of ensuring full course of immunisation among children

Ways	Andhra Pradesh	Gujarat	Haryana	Total	%
Not ensuring	25	39	7	71	48.0
With the help of Health Assistant	—	2	—	2	1.4
With the help of counterpart Workers	1	1	—	2	1.4
Community participation	2	4	—	6	4.1
Records and follow-up	19	—	30	49	33.1
Cannot say	—	—	4	4	2.8
Others	8	10	1	19	12.8
Total	53	53	42	148	

*Note:* (1) Multiple responses

(2) Data for Karnataka State not available

*Table 7.15*  
Methods of ensuring proper supply of nirodh and oral contraceptive every month adopted by Health Workers

Methods	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	%
Not ensuring regular supply	18	2	—	12	32	16.3
By personal distribution	18	49	11	29	107	54.6
Periodical enquiry with users	11	6	1	11	29	14.8
Verification of the registers of depot holders	16	4	29	—	49	25.0
Others	—	1	1	—	2	1.0
Total respondents	53	53	42	48	196	

*Note:* (1) Multiple responses



**Table 7.16**  
Ways of ensuring regular supply of contraceptives by the Health Workers to the Health Guides/Depot-holders of the area

Ways of ensuring	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Not ensuring	34	—	21	16	71 (36.8)
By personal distribution	3	37	5	29	74 (38.3)
No supply since the last 4 months	6	8	—	—	14 (7.3)
Get it during staff meetings	5	4	2	—	11 (5.7)
No regular users of contraceptives	3	—	—	—	3 (1.6)
Inform Health Assistants and M.O.	—	11	2	—	13 (6.7)
Periodic indenting	—	—	9	—	9 (4.7)
Others	2	—	3	—	5 (2.6)
<b>Total Respondents</b>	<b>53</b>	<b>53</b>	<b>42</b>	<b>45</b>	<b>193</b>

*Note:* (1) Multiple responses

(2) Figures in parenthesis indicate the percentages

**Table 7.17**  
Activities undertaken by Health Workers for removing the resistance of people

Activities	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	%
No resistance	4	1	12	5	22	11.2
Utilising the satisfied adopters	14	18	3	3	38	19.4
Involving the leaders and teachers and elders of the family members	53	53	3	18	127	64.8
Frequent contacts with resistant people	14	53	6	1	74	37.7
Try to make them understand Health and economy	—	—	16	36	52	26.5
Others	33	—	1	7	41	20.9
	2	37	1	3	43	21.9
<b>Total respondents</b>	<b>53</b>	<b>53</b>	<b>42</b>	<b>48</b>	<b>196</b>	

*Note:* (1) Multiple responses

**Table: 7.18**  
**Adequacy of supply of drugs to the Health Workers**

Adequacy of Supply of drugs	Andhra Pradesh		Gujarat		Haryana		Karnataka		Total	
	SR	NSR	SR	NSR	SR	NSR	SR	NSR	SR	NSR
Medicine	35	18	25	28	19	23	20	28	99 (50.5)	97 (49.5)
Vitamin A solution	43	10	42	11	35	7	30	18	100 (51.1)	46 (23.5)
Iron & Folic acid	49	4	34	19	36	6	31	17	150 (76.5)	46 (23.5)
Tablets										
Vaccines	35	18	31	22	36	6	39	9	141 (71.9)	55 (28.1)
Contraceptives	31	22	51	2	40	2	28	20	150 (76.5)	46 (23.5)
Total respondents	53		53		42		48		196	

**Note:** (1) SR: Supplied Regularly  
 (2) NSR: Not Supplied Regularly  
 (3) Figures in parenthesis indicate the percentages

**Table 7.19**  
**Ways of dealing with out of stock situation**

Ways of dealing	Andhra Pradesh	Gujarat	Haryana	Total
Supplied regularly	4	—	—	4 (2.7)
Never ensures	27	25	10	62 (42.5)
Getting from PHC	25	8	26	59 (40.4)
Getting from Co-Worker	11	7	—	18 (12.3)
Helpless	6	—	—	6 (4.1)
Refer to PHC	—	27	4	31 (21.2)
Inform SS, MO	—	10	—	10 (2.3)
Others	—	10	2	12 (8.2)
Total Respondents	52	52	42	146

**Note:** (1) Multiple responses.  
 (2) Data for Karnataka State not available  
 (3) Two cases of non-response one each from A.P. and Gujarat were excluded.  
 (4) Figures in parenthesis indicate the percentages.



# Management Training Needs of Health Guides

## JOB ANALYSIS

A community health guide (HG) is generally expected to cover 1000 people of a village or group of villages. If the villages have more than 1000 people then one HG is appointed. He/she will receive technical guidance from the health workers (male/female, as the case may be). Generally, the activities of HG cover the following programmes:

- Malaria
- Small pox
- Communicable diseases
- Environmental sanitation and personal hygiene
- Immunization
- Family planning
- Maternal and child health care
- Nutrition
- Vital events
- First-aid in emergencies
- Treatment of minor ailments
- Mental health.

The managerial component of the required capability is similar for most of the programmes. Therefore, the activities of the HGs can be grouped as service and education activities.

### *Service activities of HG*

Each HG is to carry out, systematically and methodically service activities such as;

- Identify who needs various services
- Plan these services
- Organize work place and house visits for providing these services
- Maintain records of services provided; and
- Review the records to assess the gaps in services

In performing the aforementioned services, the HGs are required to possess the managerial capabilities such as diagnosis of community health needs, planning of the services (such as spray work), manage supplies needed for providing services, record keepings and review. In all these service activities, he/she would receive guidance from the health workers.

### *Educational activities of HG*

A HG is supposed to carry out educational activities with respect to malaria, communicable diseases, environmental sanitation and personal hygiene, immunization, family planning, maternal and child care, nutrition, vital events registration and mental health. For such comprehensive health education activities he is required to do as follows:

Through interpersonal communication, provide information and education to person (s) directly requiring such information (*e.g.* direct advice to parents and relatives of a child suffering from malnutrition).

Plan, organise and implement campaigns and mass educational activities in cooperation with health staff; and

Use existing organizations (*e.g.* *panchayat*, health committee, adult education classes etc.) and occasions such as festivals to carry out educational activities.

In carrying out the above educational activities, the HGs require managerial capabilities to prepare an annual plan of educational activities, organise educational materials and other resources required for campaigns and work with the community and other existing organisation.

In general, therefore, the management component of HG training should emphasise orientation towards community health diagnosis of community health needs, skills in planning of services, educational activities and record keeping. A moderate amount of emphasis may also be given on training in supplies management. He/she also needs to develop appropriate attitudes and interpersonal skills to work with health worker and other organisations.

## **FINDINGS OF THE SURVEY**

In all, 112 HGs were interviewed: Andhra Pradesh (47), Haryana (32) and Gujarat (33). Of these, 100 were males and only 12 were females.

### *Background information*

Most of the HGs interviewed were between 25-40 years in age. But, in case of HGs in Haryana, there was an even distribution in the age groups 20-30, 30-40 years and 40-50 years. The median age of the HGs interviewed was 30 years (Table 8.1). About 75 per cent of the HGs interviewed were married. A majority of HGs were educated above primary but below higher secondary level. About 50 per cent of HGs interviewed in Gujarat had education only upto primary level. No HG was illiterate. The HGs interviewed had a much higher level of educational attendance as compared to *dais*. A



majority of HGs were Hindus, while instances of a Muslim or a Christian being a HG was not uncommon in Gujarat and Andhra Pradesh. A large proportion of HGs interviewed were basically engaged in agriculture for a vocation (80 per cent). However, a few shopkeepers, tailors, cobblers, housewives, labourers also work as HGs.

### *Training as HGs and working experience*

As is known, the HG scheme was introduced in the country on October 2, 1977 and an uniform pattern of training of 12 weeks was developed for HGs. This would enable them to provide immediate health care at the door steps of the community. It was observed that all the HGs interviewed had undergone a 12 weeks training course at PHCs, as prescribed by the Government of India. It was observed that most of them (about 60 per cent) had their training more than two years ago and hence had been working as HGs in the community for over two years. Almost all of them had received the kit after training and, except for the three who had not received the kit (4 per cent), all expressed the view that the training had equipped them to work as health guides.

Since most of the HGs interviewed were now on the job for more than two years, it was considered desirable to enquire about their further training needs in order to strengthen their knowledge and skill. The HGs interviewed opined that training given for curing minor ailments, family planning and immunization was insufficient and as such expressed the necessity for a more detailed training programme in these areas. In Haryana, some (25 per cent) indentified certain training needs in malaria work; in administering different medicines, about infectious diseases, in *Ayurvedic* system of medicines. Interestingly, three-fourths of the HGs interviewed in Andhra Pradesh suggested longer duration of training than what was given. In Gujarat a few HGs suggested that they needed training in family planning work, proper utilization of medicines, immunization and health education.

On the basis of replies received from the HGs, it could be informed that those who were now in the field for more than two years as HGs would require some orientation training in order to brush up their knowledge.

### *Functions*

After the completion of the three months theoretical and practical training as HG the HGs should return to their respective communities to render community health services on a voluntary basis. In rendering services, all HGs should know that their main functions are treatment of malaria, family planning, chlorination, treatment of minor ailments, imparting health education for environmental sanitation and personal hygiene and providing first-aid in emergencies. However, in practice they attached more importance to curative work and family planning. The data obtained from the survey and observations suggested a wide gap in the functions of HGs envisaged in the scheme and those perceived by the HGs themselves.

### *Pattern of work*

In order to carry out the preventive and supportive (to the health personnel) functions,

only 50 per cent of the HGs reported having not carried out specific planned activities. Few of the HGs reported that they made visits to the households for purposes of family planning advice, checking environmental sanitation, finding out fever cases and follow up and treatment of the TB cases (Table 8.2). However, nearly 60 per cent said that they consulted the community leaders and HWs for planning their activities. (Table 8.3).

### *Organisation of work*

In order to perform the activities as a HGs he/she would organise his/her work schedule. In fact, most of the sampled HGs spent on an average 2 to 4 hours per day in HG work. This was understandable since HGs are only part time community health workers. (Table 8.4).

### *HG services*

On an average, a HG attended to 5 to 10 patients a day. Most of the HGs interviewed (84 per cent) did not face any problems in rendering their services. A couple of them stated to have been facing the problems of shortage of medicine and difficulty in convincing people.

### *Referral services*

While rendering services, at times the HGs come across complicated cases which they had to refer to a health care delivery institute, such as PHC. The types of cases they generally referred were cases of fractures/injuries, high fever, malaria, T.B., burns, vomiting, diarrhoea etc. (Table 8.5). Almost 90 per cent of the cases were referred to PHCs by the HGs.

Almost all the HGs (91 per cent) followed up the cases referred by them. In doing so, most of the HGs did not face any difficulty. However, a section of them (7.6 per cent) attributed the difficulty to non-availability of health workers and inadequate transportation facility.

### *Health education activities*

Apart from treating minor ailments, the HGs also undertook educational activities on nutritious diet, environmental sanitation, family planning and immunization programme (Table 8.6).

In imparting these educational activities, it was observed that nearly 56 per cent of the HGs did not use any educational materials *i.e.* pamphlets, posters, etc. (Table 8.7).

These observations indicated that there was no organised work schedule for the HGs. While the follow-up of referral services conducted by them was claimed to be quite satisfactory, their educational activities were seemingly poor because of being conducted without any proper planning and without proper usage of educational materials. (Table 8.8)



### *Logistics (problems and suggestions)*

Most of the HGs in the states of Andhra Pradesh, Haryana and Gujarat reported not having faced any problems in rendering services. However, a couple of them attributed inadequate supply of drugs and lack of transportation facilities as major problems.

Further, they suggested their quality of work could be improved if their honorarium was increased and medicines were supplied regularly. Of course, many of them also suggested that a reorientation training could be of great help in improving their quality of work.

### *Record keeping*

As per the scheme, the HGs are not required to maintain records, yet most of the HGs interviewed maintained records, in which they generally noted down particulars about patients and medicines given to them. Some of them also noted down the chlorination of wells, fever cases for which blood slides were prepared, stock position of medicines received from PHC etc.

The records in general were used to show it to the programme personnel for checking of work done, number of patients treated and chlorination of wells done, and also for follow-up work etc.

### *Inter and intra-departmental coordination*

In his area of work, the HG has to come in contact with programme personnel and has to develop working relationship in order to get adequate support.

### *HGs and programme personnel*

On an average, three-fourths of the HGs were in contact with the medical officers once in a month. However, they very rarely met the MO/ICs. Further, the frequency of contact with the supervisors was more as compared to the MOs. Nearly 75 per cent of the HGs met the MPHWS nearly 4 to 5 times a month. However, in case of the HGs in Haryana, it was observed that health assistants had better contacts with HGs than health workers. In fact, health workers are supposed to meet the HGs more frequently and involve them in their activities.

In all these contacts, most of the HGs reported that they had had good working relationship with the programme personnel and had received adequate support from them (programme personnel) in carrying out their activities. In most of the cases, the MOs and HWs were contacted by HGs in connection with health activities and the HAs were contacted for supervision of their work. The HGs generally sought the help of programme personnel in immunization activities, chlorination of wells, motivation of family planning cases and also in spraying operations. The coordination being bi-directional the HGs helped the programme personnel in immunization, chlorination of wells and family planning activities. (Table 8.9)

The HGs did not face any problem in rendering help to the programme personnel.

However, a section of them said that they found difficulty in getting their salaries regularly. (Table 8.10).

### *HGs and trained dais*

Interestingly, the HGs interviewed in the two states provided help to *dais* mostly in conducting deliveries. On the other hand, HGs received help from the *dais* in motivation for family planning, checking of pregnancy cases and in conducting deliveries (Table 8.11)

Further, the contacted HGs did not have any suggestions to offer for improving the means of support from programme personnel. A few of the HGs in Andhra Pradesh opined that the *dais* could be of help if their remunerations were paid regularly.

In fact, the above observations revealed that the coordination between HGs and programme personnel was good and as such the HGs did not have any grivences against them. The observations also revealed that the coordination between the HGs and *dais* was extremely poor. However, the HGs did not seem to have any suggestions to offer for increasing coordination with either programme personnel or *dais*.

## **MANAGEMENT TRAINING NEEDS**

### *Implication of survey findings*

After conducting the interviews and observations with the health guides, the areas identified to have need for management training are listed below:

- Diagnosis of community health needs—surveillance, elementary epidemiology for screening of cases
- Planning of work
- Treatment of minor ailments and management of medicines.
- Health Education
- Coordination with other workers
- Leadership for community organisations
- Referral system



**Table 8.1**  
Distribution of HGs interviewed by age and sex

Age group	Andhra Pradesh			Gujarat			Haryana			Total			%
	M	F	T	M	F	T	M	F	T	M	F	T	
< 20	—	—	—	—	—	—	1	—	1	1	—	1	0.9
20-24	7	2	9	3	2	5	5	—	5	15	4	19	17.0
25-29	15	1	16	9	—	9	6	1	7	30	2	32	28.6
30-34	10	3	13	14	1	15	4	2	6	28	6	34	30.4
35-39	1	—	1	3	—	3	4	—	4	8	—	8	7.1
40-44	2	—	2	1	—	1	6	—	6	9	—	9	8.0
45-49	5	—	5	—	—	—	—	—	—	5	—	5	4.5
50	1	—	1	—	—	—	3	—	3	4	—	4	3.6
Total	41	6	47	30	3	33	29	3	32	100	12	112	

Note: (1) M—Male F—Female T—Total

(2) Data for Karnataka State not available as no HG scheme is implemented.

**Table 8.2**  
Purpose for which house visits made by HGs

Purposes	Andhra Pradesh	Haryana	Total	%
No household visits	6	13	19	24.1
To find out fever cases	1	9	10	12.7
For health education	16	6	22	27.8
For F.P. activities	10	5	15	19.0
For follow-up	—	2	2	2.5
In emergency	—	1	1	1.3
For cleanliness	—	2	2	2.5
Treatment of TB cases	—	1	1	1.3
Treatment of minor ailments	23	—	23	29.1
To enquire for environmental sanitation	15	—	15	19.0
Others	3	—	3	3.8
Total respondents	47	32	79	

Note: (1) Multiple responses

(2) Details for Gujarat State not available

101  
TM-120  
936  
COMMUNITY HEALTH CELL  
47/1, (First Floor), St. Marks Road,  
Bangalore - 560 001.

**Table 8.3**  
Persons consulted for planning activities in the village by the HGs

Persons Consulted by HGs	Andhra Pradesh			Haryana			Total	%
	Without Probe	With Probe	Total	Without Probe	With Probe	Total		
No one	1	—	1	5	—	5	6	7.6
Community leaders	35	5	40	6	3	9	49	62.0
Programme Workers								
MOs	3	5	8	4	1	5	13	16.5
BEE	4	—	4	—	—	—	4	5.1
HAs	9	7	16	6	—	6	22	27.8
MPWs	16	16	32	13	2	15	47	59.9
Total respondents			47			32	79	

Note: (1) Multiple responses

(2) Details for Gujarat State not available

**Table 8.4**  
Distribution of HGs according to the average time spent by them on HG work

Average No. of hours spent per day	Andhra Pradesh			Haryana			Total			%
	M	F	T	M	F	T	M	F	T	
< 1	1	—	1	—	—	—	1	—	1	1.3
1-2	23	2	25	—	—	—	23	2	25	31.6
2-3	7	2	9	11	—	11	18	2	20	25.3
3-4	5	2	7	3	1	4	8	3	11	13.9
4-5	3	—	3	10	—	10	13	—	13	16.5
5-6	1	—	1	—	—	—	1	—	1	1.3
6 and above	1	—	1	2	—	2	3	—	3	3.8
Available whole day	—	—	—	3	2	5	3	2	5	6.3
Total	41	6	47	29	3	32	70	9	79	

Note: (1) M — Male    F — Female    T — Total

(2) Details for Gujarat State not available



*Table 8.5*  
Referral Services: type of cases referred by HGs

Types of cases	Andhra Pradesh	Gujarat	Haryana	Total	%
High Fever	22	18	27	67	59.8
Stomach-ache	6	5	—	11	9.7
Diahorrea	6	—	10	16	14.3
Burns	9	3	—	12	10.7
Fractures/injuries	29	10	11	50	44.6
F.P. sterilization	2	—	5	7	6.3
Communicable diseases	2	3	3	8	7.1
Abnormal pregnancy	4	3	3	10	8.9
Fever with rash	10	—	—	10	8.9
Vomitting	10	15	—	25	22.3
Cholera	5	—	2	7	6.3
TB cases	6	23	2	31	27.7
Malaria	12	3	—	15	13.4
Others	7	10	3	20	17.9
Total respondents	47	33	32	112	

\* Note: Multiple responses

*Table 8.6*  
Type of educational activities undertaken by HGs

Type of Activity	Andhra Pradesh	Haryana	Total	%
Nutritious diet	25	17	32	40.5
Environmental sanitation	39	24	63	79.7
Family planning	30	14	44	55.7
Immunisation programme	24	9	33	41.8
Chlorination of wells	5	9	14	17.7
Spray of DDT	1	2	3	3.8
Communicable diseases	2	2	4	5.1
MCH	—	1	1	1.3
Advise on personal hygiene	5	—	5	6.3
Total respondents	47	32	79	

Note: (1) Multiple responses  
(2) Details for Gujarat State not available.

**Table 8.7**  
Responses of HGs according to the materials/aids used for imparting health education

Materials/aid used	Andhra Pradesh	Gujarat	Haryana	Total
No material used	31	6	21	58 (55.8)
Posters and pamphlets	8	24	10	42 (40.4)
CHV manual	—	—	2	2 (1.9)
FP charts	—	6	9	15 (14.4)
Snak-bite chart	—	—	6	6 (5.8)
Total respondents	39	33	32	104

*Note:* (1) Multiple responses

(2) Eight cases of non-response from Andhra Pradesh of HGs according to the materials/aids used for imparting health education have been excluded.

(3) Figures in parenthesis include the percentages

**Table 8.8**  
Ways of planning educational activities by HGs

Ways of planning	Andhra Pradesh	Haryana	Total	%
No specific planning	22	—	22	37.3
Try to educate them in groups	—	—	9	15.3
Accrding to needs of the area	—	5	5	8.5
According to instructions from BMO	3	4	7	11.9
According to age groups of people	—	3	3	5.1
Consulting health personnel	8	—	8	13.6
Contact individuals in their house	6	—	6	10.2
With the help of records	—	1	1	1.7
Total respondents	39	20	59	

*Note:* (1) Detail for Gujarat state not available

(2) Multiple responses

(3) 20 cases of non response 8 from Andhra Pradesh and 12 from Haryana on ways of planning educational activities by HGs have been excluded.



**Table 8.9**  
Mutual assistance between the Health Personnel and HGs

Type of assistance	Andhra Pradesh		Haryana		Total	
	Assistance sought by programme personnel	Assistance provided by HGs	Assistance sought by programme personnel	Assistance provided by HGs	Assistance sought by programme personnel	Assistance provided by HGs
No. help by health staff	2	2	3	3	5 (6.5)	5 (6.7)
Immunization	32	6	16	14	48 (62.3)	20 (26.7)
Spray operation	11	3	25	17	36 (46.8)	20 (26.7)
Family planning	10	4	8	8	18 (23.4)	12 (16.0)
Chlorination of wells	25	7	9	9	34 (44.1)	16 (21.3)
Sanitation	—	1	—	—	—	1 (1.3)
Motivation of FP cases	10	4	—	—	10 (13.0)	4 (5.3)
Required help	—	31	—	—	—	31 (41.3)
To arrange group meetings and camps	9	2	—	—	9 (11.7)	2 (2.7)
Total respondents	47	47	30	28	77	75

Note: (1) Multiple responses

(2) Details for the Gujarat State not available.

(3) Figures in parenthesis are percentages.

(4) 2 cases of assistance sought by programme personnel and 4 cases of assistance provided by HGs from Haryana State due to non-response have been excluded.

**Table 8.10**  
Ways in which support from programme personnel can be improved

Ways of improvement	Andhra Pradesh	Gujarat	Haryana	Total
Should mix with them frequently	2	—	—	2 (3.6)
Immunisation	—	—	16	16 (29.1)
In NMEP work	—	—	25	25 (45.5)
FP work	—	—	8	8 (14.5)
Cholorination of wells	—	—	9	9 (16.4)
Give additional salary	—	1	—	1 (1.8)
Give regular supply of medicines	—	4	—	4 (7.2)
More guidance to be given	2	1	—	3 (5.5)
No help sought	3	12	3	18 (32.7)
Total respondents	7	18	30	55

Note: (1) Multiple responses

(2) 57 cases (40 Andhra, 15 Gujarat and 2 Haryana), on ways in which support from programme can be improved, have been excluded due to non-response.

(3) Figures in parenthesis indicate the percentages.

*Table 8.11*  
Mutual help between HGs and trained *dais*

	Andhra Pradesh		Haryana		Total	
	Assis- tance provided to <i>Dai</i>	Assis- tance received from <i>Dai</i>	Assis- tance provided to <i>Dai</i>	Assis- tance received from <i>Dai</i>	Assis- tance provided to <i>Dai</i>	Assistance received from <i>Dai</i>
No trained <i>dai</i> in the village	—	—	2	2	2	2
No assistance	37	37	20	20	57	57
Type of assistance						
Motivating mothers for sterilization	—	2	—	6	—	8 (42.1)
Checking pregnancy cases	—	—	—	6	—	6 (31.6)
Immunisation work	1	1	2	1	3 (15.8)	2 (10.5)
Reporting about birth	1	—	3	—	4 (21.1)	1 (5.3)
Helping in conducting delivery	9	5	5	—	14 (73.7)	5 (26.3)
Accompany at nights	—	—	2	—	2 (10.5)	—
Provide drugs whenever needed	3	—	—	—	3 (15.8)	—
Family planning	1	—	—	—	1 (15.3)	—
Others	3	—	—	—	3 (15.8)	—
Total	9	9	10	10	19	19

*Note:* (1) Multiple responses for type of assistance

(2) Details for Gujarat State not available.

(3) One case of non-response from Andhra Pradesh on each topic of assistance provided to *dai* and assistance received from *dai* have been excluded.

(4) Figures in parenthesis indicate the percentages.



## Management Training Needs of Trained *Dais*

### JOB ANALYSIS

#### *Responsibilities of trained dais*

The *dai* serves as a link between the families in her village and the health workers (female *i.e.* ANM). The main activity of the *dai* is to provide MCH and family planning services. Therefore, the managerial responsibilities and capabilities required may be minimal. Fourteen MCH activities (1 to 14) are enumerated in the Government of India manual on curricula for training of staff of the primary health care. These tasks require that all pregnancies in her area are managed well and all eligible couples receive education and service with respect to family planning. All births and deaths in her area are to be reported to the health worker (male) or health worker (female)/ANM.

### SURVEY FINDINGS

#### *Background information*

In the state of Karnataka, Andhra Pradesh, Haryana and Gujarat, 181 trained *dais* were interviewed. Nearly two-third of the *dais* were above 40 years in age. In Gujarat about 64 per cent were in the age range of 30-50 years; in Haryana, more than eighty per cent were between 25 and 50 years; in Karnataka and Andhra Pradesh 50 per cent were above 50 years (Table 9.1) While two-third of them were married, the remaining one-third were widowed. In Andhra Pradesh, about 50 per cent were widow, in Gujarat and Karnataka one-fourth and one-third respectively were widowed. Except for 10 Muslim and One Christian *dai*, the rest were Hindus. The Muslim *dais* were found in Gujarat and Andhra Pradesh.

Among 181 *dais* interviewed, 150 were illiterate. Among the remaining all literates, 10 were without any formal education, 10 studied upto primary level and 11 above primary level (Table 9.2). For many of the interviewed trained *dais*, birth attendance was a traditional family vocation. Others reported that they were either housewives, or tailors, or sweepers, or labourers and birth attendance was a subsidiary vocation.

#### *Professional experience and training*

The distribution of *dais* in terms of length of their working as *dai*, indicated that they

were not new to the profession and many of them had 4 to 10 years of experience. Nearly one-half of the *dais* interviewed had more than 10 years of experience. In Andhra Pradesh, one-fifth of the interviewed *dais* had been in the profession for more than 22 years. Interestingly, one-half of the trained *dais* interviewed in Haryana had had only 1 to 4 years of professional experience. This discrepancy in the years of experience of the trained *dais* was partly due to the fact that some States like Haryana had recruited rather younger women for *dai* training, whereas the other states had included the middle aged *dais* with longer work experience as *dai* (Table 9.3).

Most of the *dais* found the training they had undergone as useful. However, it was found that only about 50 per cent of them had put into practice some of their knowledge gained during the training in conducting deliveries and in ensuring some hygienic conditions. As far as the other half was concerned, it was rather difficult to ascertain whether training had really meant any change in their practice. But it should be stated that the training period was short (about a month) and that most of the *dais* did not get much of an on-the-spot training from the female workers. Most of the *dais* who had received the training more than three years back, however, expressed a desire to undergo a reorientation training.

### *Planning and organisation of work*

More than 50 per cent of the trained *dais* conducted three or more deliveries per month. Most of the deliveries were conducted within the village of their residence, and a few outside it. The figures also varied from region to region, depending to a large extent on the population density of the village concerned and on the presence of other *dais* (trained or untrained) in the village (Table 9.4).

The *dais* visited the women at early stage of their pregnancy. In fact, it was reported that about 40 per cent of the *dais* had paid their first visit before the onset of the fifth month of pregnancy. More frequent visits were made during the seventh and eighth months. But as the pregnancy advanced, the frequency of visits became more frequent and maximum number of visits took place in last month of the pregnancy. During their visits 59 per cent of the *dais* advised pregnant women to undergo immunization with tetanus toxoid, and 39 per cent of the *dais* educated them about nutritious diet. However, only a few *dais* advised on sanitation and cleanliness. Twenty seven per cent of the *dais* advised the pregnant women on the need for regular check up and general precautions to be taken till delivery. A few of them talked about family planning also (Table 9.5 and 9.6).

Trained *dais* besides providing post-natal care are expected to help in getting pregnant women and newly born children immunised. The study revealed that about 51 per cent of the *dais* either advised on the necessity of immunization of children and 26 per cent accompanied the mother to the health centre for this purpose. Forty per cent of *dais* did not follow any specific method to ensure completed coverage of immunization. About 27 per cent of *dais* adopted personal contact to ensure complete coverage (Table 9.7 and 9.8)

The *dais* are also expected to do educational activities related to immunization, nutritious diet, hygiene, environmental sanitation, family planning etc. The study



finding showed that *dais* provided advice in the areas. (Table 9.9 and 9.10). mostly in cleanliness and personal hygiene, nutritious diet and family planning.

### *Coordination with the female workers*

Coordination of activities between the *dais* and the female workers, as perceived by the former, seemed to be very high though varying in degree from state to state. For example, where as more than 85 per cent of the trained *dais* in A.P. and Haryana sought and got help from the female workers, this figure was about 60 per cent in Gujarat (Table 9.11). In most of the cases, this help was limited to cases of anticipated complication in delivery. On the other hand, the female workers sought the help of the *dais* for various purposes, *e.g.* assistance in delivery, cleaning of clothes, helping in sterilization of the equipment and other petty jobs during delivery and for family planning work. The *dais* did not find any problem in providing such help. In fact, quite few of them reported that the female worker did not ask them for any help (Table 9.12 and 9.13).

### *Logistics*

After the training, the *dais* are supposed to be given a midwifery kit each, and to be paid an honorarium of Rs. 2/- for each delivery they conducted.

Most of the *dais* had received the kit soon after the training, but about 15 per cent of the trained *dais* had not received any kit at all. In 80 per cent of the cases, the kits were not replenished regularly, in 70 per cent of the cases the original kits were not been replenished at all. Given this situation, and also the fact that the *dais* being poor, would not be in a position to afford to buy the stationery, anti-septic agents etc., the kits were as good as not having been given at all. As far as the honorarium is concerned, the situation was no better. More than 85 per cent of trained *dais* in A.P., 75 per cent in Haryana and as many as 90 per cent in Gujarat and 99 per cent in Karnataka did not receive any payment from the Government. It is partly due to their lack of awareness of the scheme and partly due to the cumbersome procedure involved in receiving even the paltry amount, that most of them did not get the honorarium. Almost all the *dais* received some payment from the client for conducting a delivery. On an average it amounted Rs. 5/- and/or 5 kg of grain in each case, by means a meagre payment.

## **MANAGEMENT TRAINING NEEDS**

### *Implications of study findings*

After conducting the interviews and observations with *dais*, the areas that were identified as management training needs are listed below.

- Planning and scheduling house visits
- Surveillance for high risk cases in mothers and children
- Referral system
- Proper management of ante-natal care and deliveries

Management of post-natal care  
Relationship with female health workers  
Leadership for community organisations  
Health education  
Official procedures for getting honorarium



*Table 9.1*  
Age distribution of trained *dais*

Age Group (Years)	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	Percentage
< 20						
20-24	—	—	5	—	5	2.8
25-29	—	—	8	—	8	4.4
30-34	3	3	4	2	12	6.6
35-39	6	7	5	9	27	14.9
40-44	4	15	8	2	29	16.0
45-49	10	9	7	8	34	18.8
> 50	25	19	2	20	66	36.5
Total	48	53	39	41	181	100.00

*Table 9.2*  
Educational status of trained *dais*

Educational status	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	Percentage
Illiterate	35	50	29	36	150	82.9
Literate, no formal education	7	—	2	1	10	5.5
Upto primary	3	3	4	—	10	5.5
Above primary	3	—	4	4	11	6.1
Total	48	53	39	41	181	100.0

**Table 9.3**  
Distribution of trained *dais* according to the period since working as *dai*

Period (years)	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	Percentage
≤ 1	1	—	—	2	3	1.7
1-4	3	2	20	2	27	15.1
4-7	10	6	6	5	27	15.1
7-10	5	8	4	11	28	15.6
10-13	6	8	—	5	19	10.6
13-16	6	7	1	4	18	10.1
16-19	—	—	2	2	4	2.2
19-21	5	6	5	4	20	11.2
> 22	10	16	1	6	33	18.4
<b>Total</b>	<b>46</b>	<b>53</b>	<b>39</b>	<b>41</b>	<b>179</b>	

*Note:* (1) Two cases from Andhra Pradesh of trained *dais* according to the period since working as *dai* have been excluded due to non-response.

**Table 9.4**  
Distribution of trained *dais* by average number of deliveries conducted per months (in villages of their residence)

Average no. of deliveries	Andhra Pradesh	Haryana	Karnataka	Total
0	2	—	—	2 (1.6)
1	9	—	10	19 (14.8)
2	22	8	12	42 (32.8)
3	10	6	9	25 (19.5)
4	2	7	5	14 (10.9)
5	1	5	4	10 (7.8)
6	1	2	1	4 (3.1)
above 6	1	11	—	12 (9.3)
<b>Total</b>	<b>48</b>	<b>39</b>	<b>41</b>	<b>128</b>

*Note:* (1) In Gujarat 53 *dais* did conduct the deliveries in villages of their residence but their data by average number of deliveries per month was not available. Hence, the table does not include data for Gujarat State.

(2) Figures in parenthesis are percentages.



**Table 9.5**  
Visits at different months of pregnancy by trained *dais*

Months of pregnancy	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	Percentage
2nd	6	3	1	—	10	5.5
3rd	10	8	4	6	28	15.5
4th	12	14	3	6	35	19.3
5th	33	22	5	11	71	39.2
6th	20	14	11	13	58	32.0
7th	33	45	16	10	108	59.7
8th	19	44	24	17	104	57.5
9th	39	51	16	—	106	58.6
Total respondents	48	53	39	41	181	

*Note:* Multiple responses.

**Table 9.6**  
Type of ante-natal care and advice provided by trained *dais* to pregnant women

Type of care/ advice	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Care/advice not provided	—	—	—	4	4 (2.3)
Immunisation against T.T.	15	45	30	17	107 (61.1)
Nutritious diet	21	18	13	19	71 (40.6)
Regular check up	18	11	1	18	48 (27.4)
General precautions	17	26	1	4	48 (27.4)
Advice on family planning	3	4	5	4	16 (9.1)
Sanitation/cleanliness	7	4	6	1	18 (10.2)
Health education	—	—	—	4	4 (2.3)
Personal hygiene	11	—	—	4	15 (8.6)
Advice for vitamin tablets	—	20	—	—	20 (11.4)
Total respondents	45	52	37	41	175

*Note:* 1. Multiple responses

2. Figures in parenthesis are percentages.

3. Six cases (3 Andhra Pradesh, 1 Gujarat and 2 Haryana) on the type of ante-natal care and advice provided by a trained *dai* to the pregnant women have been excluded due to non-response.

Table 9.7

The ways in which the trained *dais* help in getting pregnant women and newly born children immunised

Ways	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Accompany mother to PHC	10	2	32	1	45 (25.7)
Advise them about immunisation	36	34	5	14	89 (50.9)
Inform ANM of the area about such cases and get immunisation done	8	—	2	10	20 (11.4)
Remind them regularly for taking up immunisation at proper time	3	26	3	4	36 (20.6)
By motivation	5	—	1	—	6 (3.4)
Help drug immunisation	—	—	—	6	6 (3.4)
Total respondents	43	52	39	41	175

Note: (1) Multiple responses

(2) Six cases (5 Andhra & One from Gujarat) on the ways in which trained *dais* help pregnant women and newly born children *i.e.* immunised have been excluded due to non-response.

(3) Figures in parenthesis are percentages.

Table 9.8

Ways in which trained *dais* ensure complete coverage of immunisation of pregnant women and children

Ways	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
No mechanism followed	2	—	9	36	47 (39.8)
By reminding them from time to time and accompanying them to centre	12	1	16	—	29 (24.6)
By personal contacts	20	1	9	2	32 (27.1)
Through immunisation camps	2	—	3	2	7 (5.9)
Local leaders and Health Workers	—	—	—	1	1 (0.8)
Inform ANM	—	2	—	—	2 (1.7)
Total	36	4	37	41	118

Note: (1) Figures in parenthesis indicate the percentages.

(2) 63 cases (12 Andhra Pradesh, 49 Gujarat and 2 from Haryana) on ways in which trained *dais* ensure complete coverage of immunisation of pregnant women and children have been excluded due to non-response.



**Table 9.9**  
Type of post-natal care and advice provided by trained *dais* to mothers\*

	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total	Percentage
Cleanliness and personal hygiene	27	31	18	3	79	43.6
Immunization of children	3	14	9	3	29	16.0
Family planning	3	10	18	12	43	23.8
Nutritious diet	14	36	6	5	61	33.7
Refer to hospital	1	3	—	7	11	6.1
Health education	23	20	—	12	55	30.4
General precautions	—	—	3	—	3	1.7
Total respondents	48	53	39	41	181	

\*Multiple responses

**Table 9.10**  
Type of educational activities undertaken by trained *dais*

Type of educational activity	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Immunisation of children	37	29	17	7	90 (52.9)
Nutritious diet	5	5	4	9	23 (13.5)
Personal hygiene	2	3	2	3	10 (5.9)
Advice on family planning methods, need, etc.	41	51	28	14	134 (78.8)
Environmental sanitation					
Distribution of posters and pamphlets	—	1	1	—	2 (1.2)
No educational activities undertaken	—	—	—	13	13 (7.6)
Total respondents	45	51	33	41	170

*Note:* (1) Multiple responses

(2) 11 cases (3 Andhra, 2 Gujarat and 6 Haryana) on type of educational activities undertaken by trained *dais*, have been excluded on account of non-response.

(3) Figures in parenthesis are percentages.

Table 9.11

Distribution of trained *dais* according to help received from ANMs and help provided to ANM

Help sought	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
<i>Dais</i> not having sought help from ANMs	2	22	10	3	37 (20.4)
<i>Dais</i> sought help from ANMs and received it	44	28	28	34	144 (74.0)
<i>Dais</i> sought help from ANMs and did not receive it	2	3	1	4	10 (5.5)
Total	48	53	39	41	181
ANMs never sought help from trained <i>dais</i>	2	4	16	5	27 (14.9)
ANMs took help from trained <i>dais</i>	46	49	23	36	154 (85.1)
Total respondents	48	53	39	41	181

*Note:* Figures in parenthesis are percentages

Table 9.12

Type of help sought by trained *dais* from ANMs

Help sought	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total
Checking pregnant women	—	5	—	4	9 (5.4)
Help in complicated delivery cases	43	25	24	19	117 (70.1)
Help in immunisation of mother and children	4	21	—	7	32 (19.2)
For seeking guidance during delivery time	—	—	—	3	3 (1.8)
During emergency	—	5	—	5	10 (6.0)
Medicine	—	—	—	4	4 (2.4)
Still birth	—	—	—	1	4 (0.6)
Bleeding cases	—	—	—	2	2 (1.2)
Others	13	2	—	—	15 (8.9)
No help sought for	4	25	11	7	47 (28.14)
Total respondents	47	40	39	41	167

*Note:* (1) Multiple responses

(2) Figures in parenthesis indicate the percentages.

(3) In Gujarat 13 *dais* and in Andhra Pradesh one *dai* did not respond.



*Table 9.13*  
Type of help asked for by ANMs

Type of help	Andhra Pradesh	Gujarat	Haryana	Karnataka	Total Percentage
ANM never took help from <i>dais</i>	—	—	16	4	20 (12.2)
Assistance in delivery	14	9	12	2	37 (22.6)
For follow-up of visits	17	2	3	2	24 (14.6)
Cleaning clothes/petty works	—	27	3	—	30 (18.3)
Sterilization of equipments	—	—	1	—	1 (0.6)
For family planning work	22	3	1	31	57 (34.8)
Health education	—	—	1	—	1 (0.6)
In case when there is time for deliveries	—	15	1	3	19 (11.6)
Immunisation	—	—	—	18	18 (11.0)
Others	10	—	—	7	17 (10.4)
No response	2	14	1	—	
Total respondents	46	39	38	41	164

*Note:* (1) Multiple response

(2) 17 cases (2 Andhra Pradesh, 14 Gujarat and one Haryana) of type of help asked by ANMs have been excluded due to non-response.

(3) Figures in parenthesis indicate the percentages.





## Workshop Approach

A workshop on health management with emphasis on health management training was organised by the National Institute of Health and Family Welfare from 14th to 17th December 1981.

Participants in the workshop consisted mainly of two officers from PHC, two officers from district level, three state level programme officers, and the principals of HFWTCs from the three states of Andhra Pradesh, Gujarat and Haryana. Besides, the representatives from Rural Health Division of the Ministry of Health and Family Welfare, Government of India, Central Health Education Bureau and All India Institute of Hygiene and Public Health of Calcutta also attended. The principal investigators of the study from NIHFW, IIM Bangalore, IIM Ahmedabad and the Gandhigram Institute of Rural Health and Family Welfare Trust also attended.

The objectives of the workshop were:

- To identify the management problems at the block, district, state and central levels.

- To identify the training needs of officials working at these levels for strengthening the management.

- To provide a forum for various categories of health workers to discuss their operational problems; and

- To suggest or find out tentative solutions to their management problems.

The workshop was inaugurated by Shri C.V.S. Mani, IAS, Additional Secretary (Health), Government of India and the concluding session was presided over by Prof. Somnath Roy, Director, NIHFW. Dr. Mya Tu, Regional Advisor of the W.H.O. attended both the inaugural and concluding sessions.

The participants were divided into three groups for group work. At the plenary sessions their observations and recommendations were read out and discussed. All the three groups were assigned the same tasks *viz* identifying management problem at PHC level, management problem at district level and management aspects of state-centre relationship.

The problems identified by the groups as training needs and their recommendations for ensuring better working atmosphere and morale at all levels are given below:

## MANAGEMENT PROBLEMS AT PHC LEVEL

### PLANNING

#### *Problems*

- (i) Lack of planning for health services at PHC level and inadequacy of work plans
- (ii) Lack of participation of the community and health workers in planning at the PHC level.

#### *Related Training Needs*

Managing primary health care services (planning health activities)—assessing the situation, selecting problems, setting objectives, reviewing, obstacles and limitations and making a plan.

Means of securing community participation and involving peripheral workers in work plans.

### ORGANISATION

- (i) Lack of team approach and leadership for rural health problems.

- (a) Concept of health team
- (b) How to lead a health team
- (c) Organising health team activities
- (d) Knowledge about job description
- (e) Delegating authority and responsibility
- (f) Using different styles of supervision

### COORDINATION

- (i) Lack of effective coordination between staff and other health functionaries and other concerned agencies and voluntary institution.
- (ii) Lack of coordination between health care institutions, community and other sectors.

- (a) Fundamentals of effective coordination and its techniques.
- (b) Coordinating the work of health team
- (c) Monitoring and redirecting a programme and supervision

### PERSONNEL

- (i) Lack of delegation of powers to the MO(PHC) regarding leave, transfer and incentives.

- (a) Overview of personnel management
- (b) Selection
- (c) Training
- (d) Performance appraisal
- (e) Problems of discipline with an organisation



## FINANCIAL AND MATERIAL RESOURCES

- (i) Lack of knowledge regarding proper maintenance of financial records and its related rules and regulations
- (ii) Lack of knowledge regarding procurement procedures, inventory control, storage, issue, supplies, and timely replenishment
- (iii) Inadequate availability of drugs and equipment
- (iv) Lack of proper space for storage
- (a) Knowledge about financial rules
- (b) Principles of stores management and drugs.
- (c) Space management

## MANAGEMENT INFORMATION SYSTEM

- (i) Multiplicity of records and reports and their maintenance
- (ii) Reliability and validity of generated data
- (iii) Lack of proper and timely feedback particularly downwards
- (a) Methods of simplification and maintenance of records
- (b) Reporting system

## MONITORING AND EVALUATION

- (i) Lack of knowledge of the need of monitoring system and its various facets.
- (ii) Lack of proper orientation to the methods of evaluation of programmes as well as personnel.
- (iii) Absence of monitoring plans
- (iv) Lack of skills in evaluating services and programmes.
- Evaluating health activities*
  - (a) How to evaluate achievements?
  - (b) How to evaluate work progress?
  - (c) Appraising staff performance
  - (d) Evaluating use of resources
  - (e) Management Audit

## MANAGEMENT PROBLEMS AT DISTRICT LEVEL

### PLANNING

#### *Problems*

- (i) Lack of utilisation of available data for planning the delivery of health care services.
- (ii) Lack of clear perception of the goals of health programmes

#### *Related Training Needs*

- (a) Programme objectives, strategies, rationale for target setting
- (b) Decision regarding relative priorities
- (c) Principles of resource-based planning

- (iii) Lack of appreciation of interdependency in goals for various health programmes and their impact
- (iv) Lack of awareness about rationale behind programme targets
- (v) Lack of knowledge about area planning
- (vi) Lack of planning for developing a two-way referral system
- (d) Method of area planning
- (e) Activity planning
- (f) Facility planning
- (g) How to prepare a plan for implementing two-way referral system
- (h) Planning for the health care of special interest groups or specialised services in the area

## ORGANISATION STRUCTURE

- (i) Lack of clearly defined work and responsibilities among Dy. CMOs and their jurisdiction
- (ii) Prevalence of role ambiguities amongst CMOs/DHOs etc. as programme manager or programme administrator
- (iii) Varying responsibilities of DFWO in the districts with and without MPW Scheme.
- (a) Types of organisation, its structure and function
- (b) Programme management and programme administration
- (c) Methods of allocation of responsibilities
- (d) Role ambiguities and their resolution
- (e) Concepts of vertical and horizontal programmes/ uni-purpose vs multi-purpose functional implications for future perspective

## PERSONNEL MANAGEMENT

- (i) Lack of skills in using appropriate criteria for performance of the workers in relation to programmes objectives.
- (ii) Lack of objective system of performance appraisal
- (iii) Inability to redress early grievance
- (iv) Lack of awareness of supportive supervision, and employee guidance and counselling
- (v) Lack of skills in promoting and sustaining workers' motivation.
- (vi) Inability to appreciate the value of inservice training, staff meeting, on the job guidance as input in health manpower development.
- (vii) Lack of assessment of training needs,
- (a) Methods and techniques of performance appraisal
- (b) Procedures of grievance redressal
- (c) Work motivation, reward/ incentive system
- (d) Need and value of training and continuing education to the employees and its assessment, organisation and evaluation



organisation and evaluation of training programmes on continuing basis.

## **FINANCIAL AND MATERIAL RESOURCES**

- |   |   |
|---|---|
| (i) Centralization of the purchase and supply of drugs and equipment                                    | (a) Knowledge about financial rules, regulations and records. |
| (ii) Inadequate knowledge of inventory control and material planning                                    | (b) Drawing, disbursing and delegation of powers.             |
| (iii) Lack of systematic maintenance and timely repairs of equipment, vehicles, transport, fridge, etc. | (c) Methods of inventory control.                             |
|   | (e) Condemnation procedure                                    |
|   | (e) Financial control   |
|   | (f) Transport and equipment management                        |

## **MANAGEMENT INFORMATION SYSTEM, MONITORING & EVALUATION**

- |  |   |
|--|---|
| (i) Lack of monitoring plans in accordance with the programme objectives | (a) Preparation of a monitoring plan              |
| (ii) Lack of an evaluation system for the programme appraisal            | (b) Development of research skills for evaluation |
| (iii) Lack of proper and timely feedback.                                |   |
| (iv) Lack of impact evaluation   |   |
| (v) Indifference towards obtaining users' preference and satisfaction.   |   |

## **GENERAL RECOMMENDATIONS**

### **PHC LEVEL**

1. Multipurpose workers strategy may be combined with that of the health guides and birth attendants under rural health scheme.
2. A block medical officer's post (class-I) may be created with sufficient authority to deal with the health institutions within the block.
3. Sub-centres within a PHC may be reorganised according to the norms given by the Centre.
4. Roles and responsibilities of different medical officers of the PHC and sharing of the tasks may be put in clear focus.
5. To strengthen the curative services at the PHC, provision for more investigative facilities by way of laboratory technicians, X-ray etc. may be made.
6. Interest-free loan may be provided to MO for purchase of motor-cycle for greater mobility and effective supervision.
7. Drugs for minor ailments may be provided to health workers (male).
8. A mechanism for greater coordination and control among opinion leaders, health guides, birth attendants (trained) and other health functionaries may be developed.
9. An effective system for mobilisation of community resources and participation

may be evolved.

10. Methods and techniques of studying consumers' behaviour may be studied.
11. Due recognition may be given to efficient and productive workers.

## DISTRICT LEVEL

1. A core group may be constituted by the Central Government to study the varying patterns and suggest an optimal uniform organisational structures for the district level to the Union Health and Family Welfare Ministry.
2. Referral services effective only upto PHC level, should be strengthened and improved up to district level and a two-way referral system should be promoted.
3. The district officers may be oriented to revitalise the functions of various district committees for achieving the objectives of primary health care.
4. Efforts to involve voluntary agencies, *mahila mandals* and other developmental/social welfare agencies should be made.
5. Some fund should also be placed at the disposal of health worker (Male) for provision of medicines.
6. The system of purchase of medicine should be decentralised for effective implementation of primary health care service delivery.
7. The annual budget allocation for medicine by the state headquarters should be made quarterly to bring about better utilisation of funds at the end of the financial year.
8. The existing training facilities available in the central training institutes and the health and family welfare training centres remain under-utilised in most of the training centres. The state governments are recommended to ensure that the health personnel are deputed for training and the persons deputed for training are relieved of their duties to attend the training courses.
9. There is an overall shortages of female health workers and supervisors and yet quite a large number of ANMs are being utilised in the hospitals in place of the nursing staff. The state governments should ensure that all the ANMs trained are placed in the sub-centres in the rural areas.
10. A curriculum for integrated training, including management training, of the medical officer of the primary health centres has been developed and sent to the state governments. The state governments are recommended to conduct at least one such course in each training centre and evaluate it for further improvement.



## Plan for Training Modules

In phase-I of the study of management training needs for the categories of workers at primary health centres level have been identified through scrutiny of job descriptions, interviews with respective personnel and observation of their pattern of working and were later discussed in a workshop of senior level health administrators and medical officers of primary health centres.

*Phase-II* of the study, to be devoted to the development of appropriate and suitable training modules, will try these for their feasibility and effectiveness.

In order to develop management training modules for different categories of health personnel at PHC level as phase II of the study, the collaborating institutions have discussed the methodology during their review meetings. The scheme of action is briefly described as follows:

- Step-I*                      Matching against the management needs already identified, the broad tasks will be defined and listed down; these will again be broken down into activities so that the training could be given specifically for each activity.
- Step-II*                      Based on the interviews and observations carried out in Phase-I, deficiencies will be discussed to ascertain to what extent fresh or further knowledge should be imparted and in what manner. It is important that attitudinal as well as behavioural change (for appropriate motivations and accurate skill) have to be brought about during the training. Keeping this in mind lesson plans will be prepared for each task breaking it down into sub-tasks. While preparing the lesson plan the method of teaching and use of appropriate and suitable aids will also be discussed and decided upon.
- Step-III*                    Having prepared the lesson plan, the duration of the training and allotment of time for different topics and sessions will be decided upon by the collaborating institutions, in a meeting which will be held to review the draft modules. A curriculum will be drawn up specifically for each category of workers.
- Step-IV*                    Each collaborating institutions will undertake feasibility trial of the

training module for one or two categories of workers as decided upon in the meeting for review of draft modules.

*Step-V* The evaluation will be carried out concurrently during the training as also at the end of the training.

*Step-VI* Based on the findings of the evaluation study, the training modules will be suitably modified and finalised to be made into a package which can be utilised uniformly throughout the country.

Further, the collaborating institutions will meet and decide about the strategies to be followed for undertaking such management training course in all the States and will give recommendations with regard to the staff needs and physical facilities etc. necessary to strengthen the existing facilities in the country for training purposes.











